ASOPROCÁNCER
Asociación Pro Congreso de Cancerología

XXII Congreso Colombiano de Cáncer

19, 20 y 21 de marzo de 2026

Inteligencia artificial en oncología
Atención integral centrada en el paciente

Centro de convenciones Neomundo
Bucaramanga

Con el aval de:

Dr Nicolas Villareal Trujillo
Urólogo Oncólogo
FOSCAL – FOSCAL Internacional

mHSPC de bajo volumen: ¿ tratar el primario y/o MDT? Evidencia y limites

XXII Congreso Colombiano de Cáncer

Conflicto de Interés

- Ninguno

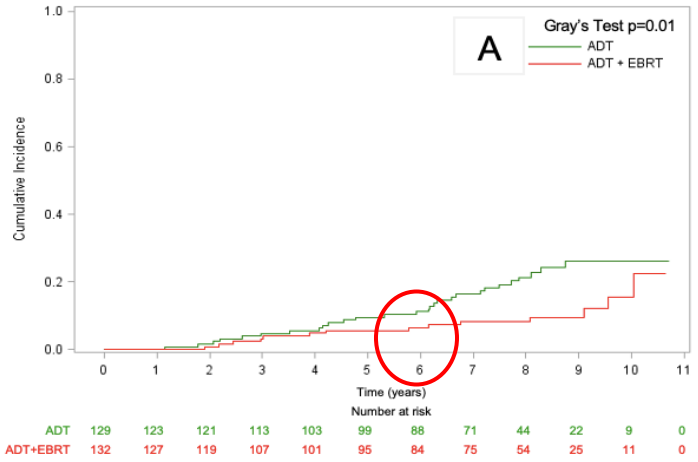
RADIOTERAPIA AL PRIMARIO

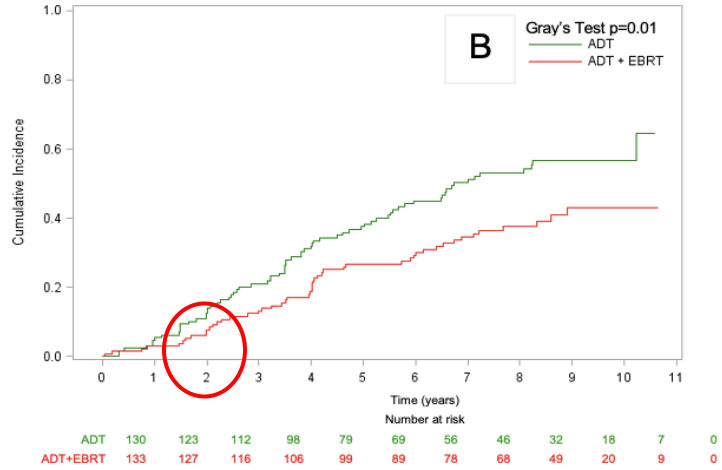
Long-term androgen deprivation, with or without radiotherapy, in locally advanced prostate cancer: updated results from a phase III randomised trial

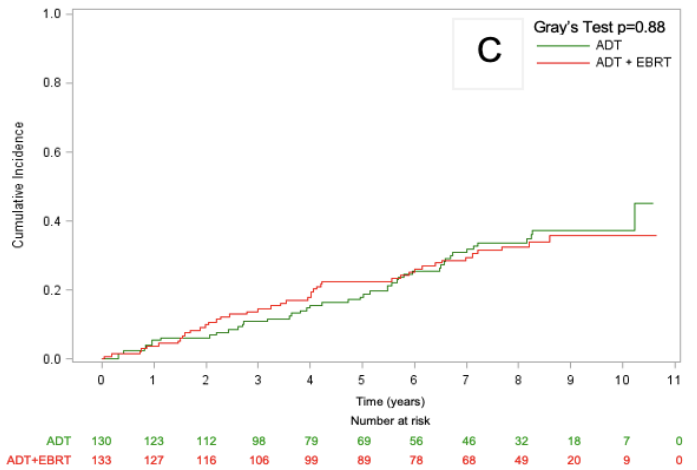
Paul Sargos*, Nicolas Mottet†, Carine Bellera‡ and Pierre Richaud*

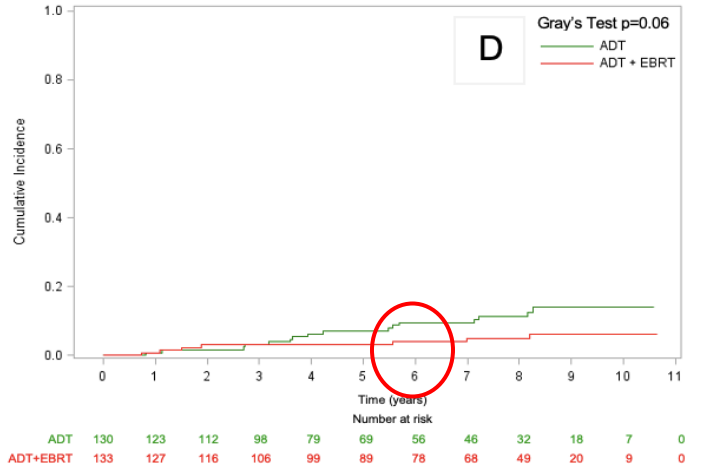
Supervivencia Cáncer Especifica	Supervivencia libre de Progresión loco regional
Supervivencia Libre de Metástasis	Tiempo a la Metástasis

Supplementary Figure 1: Cumulative incidence for disease-specific survival (A), locoregional progression-free survival (B), Metastasis free survival (C), and time to metastasis (D), according to the allocated treatment: androgen deprivation therapy combined with external beam radiation therapy (ADT+EBRT) or androgen deprivation therapy alone (ADT)









Final Report of the Intergroup Randomized Study of Combined Androgen-Deprivation Therapy Plus Radiotherapy Versus Androgen-Deprivation Therapy Alone in Locally Advanced Prostate Cancer

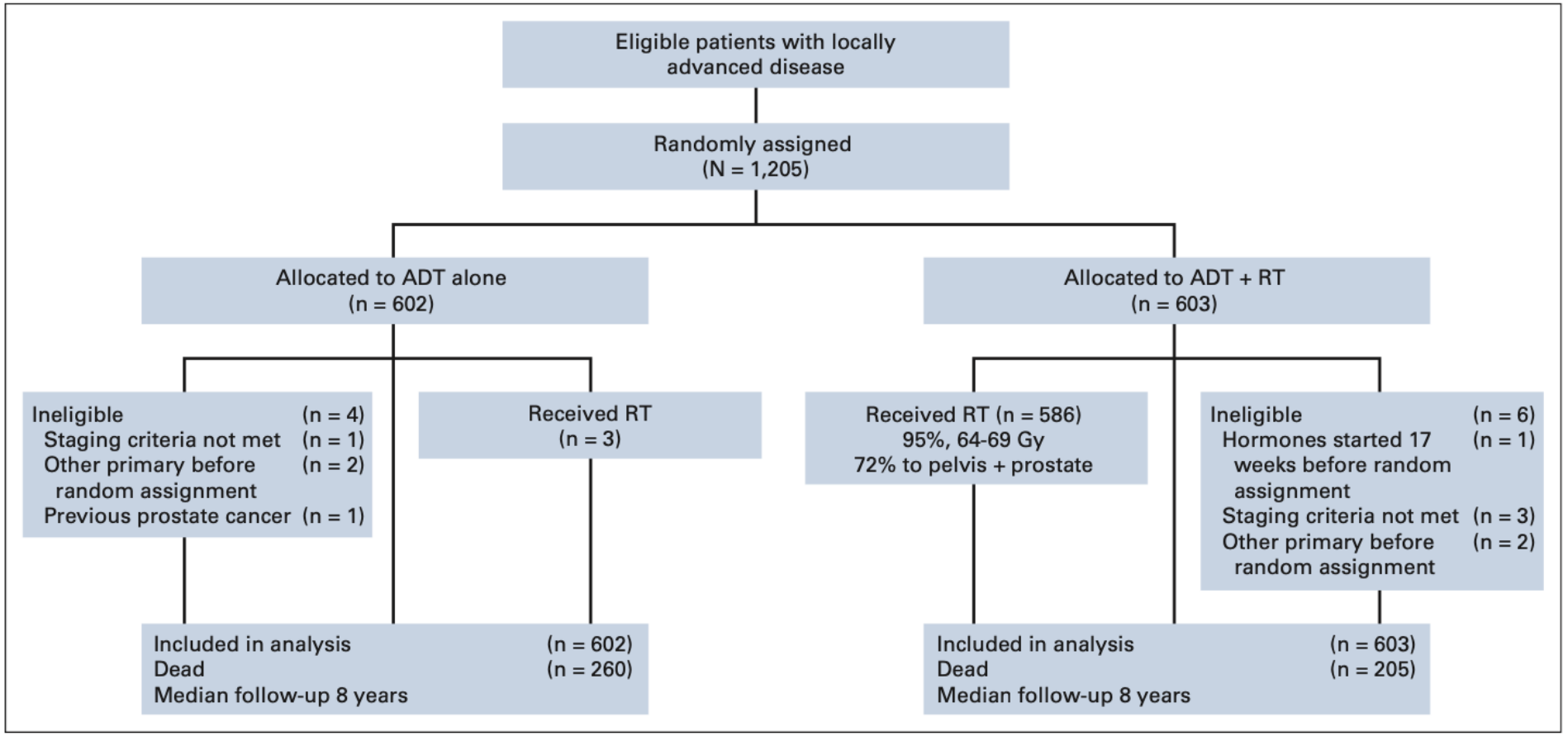


Fig 1. CONSORT diagram. ADT, androgen-deprivation therapy; RT, radiotherapy.

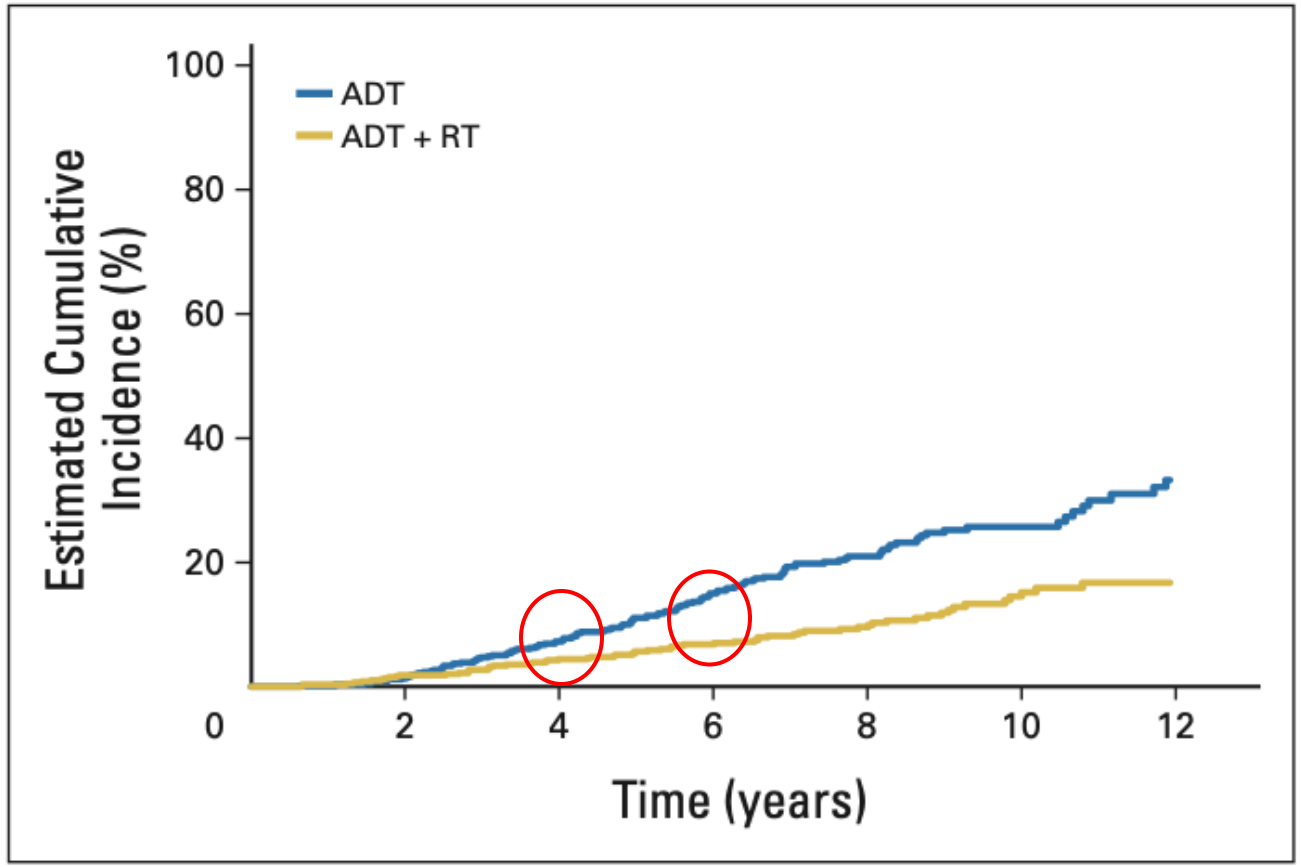
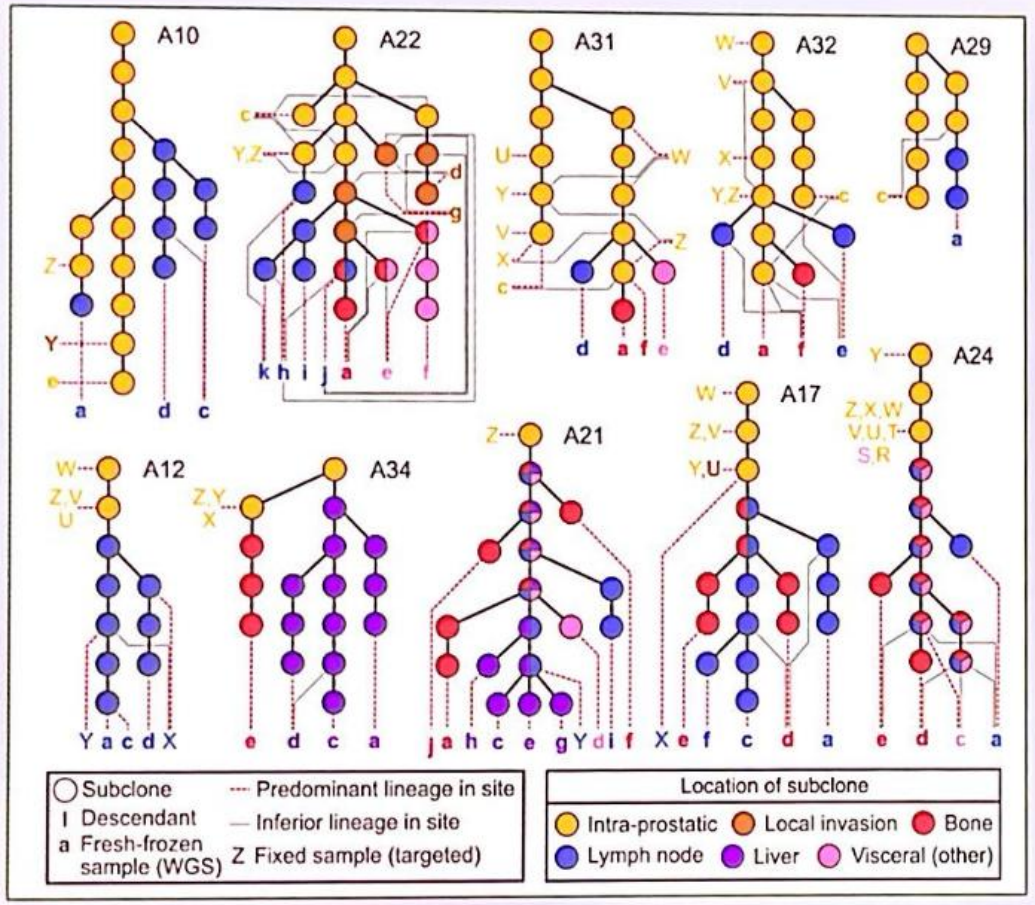


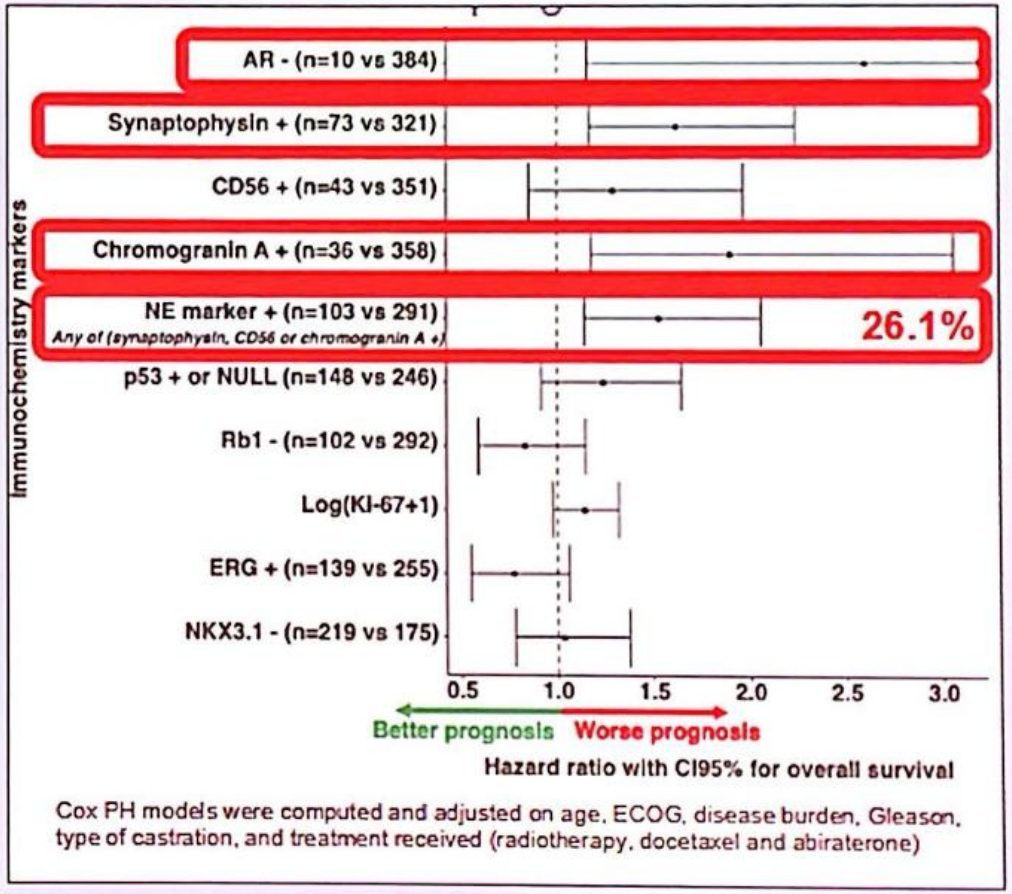
Fig 3. Deaths from prostate cancer. ADT, androgen-deprivation therapy; RT, radiotherapy.

RADIOTERAPIA AL PRIMARIO EN ENFERMEDAD METASTASICA

Primary tumors host clones with M+ potential that may arise early

EMUC25
13-16 November 2025
Prague, Czech Republic

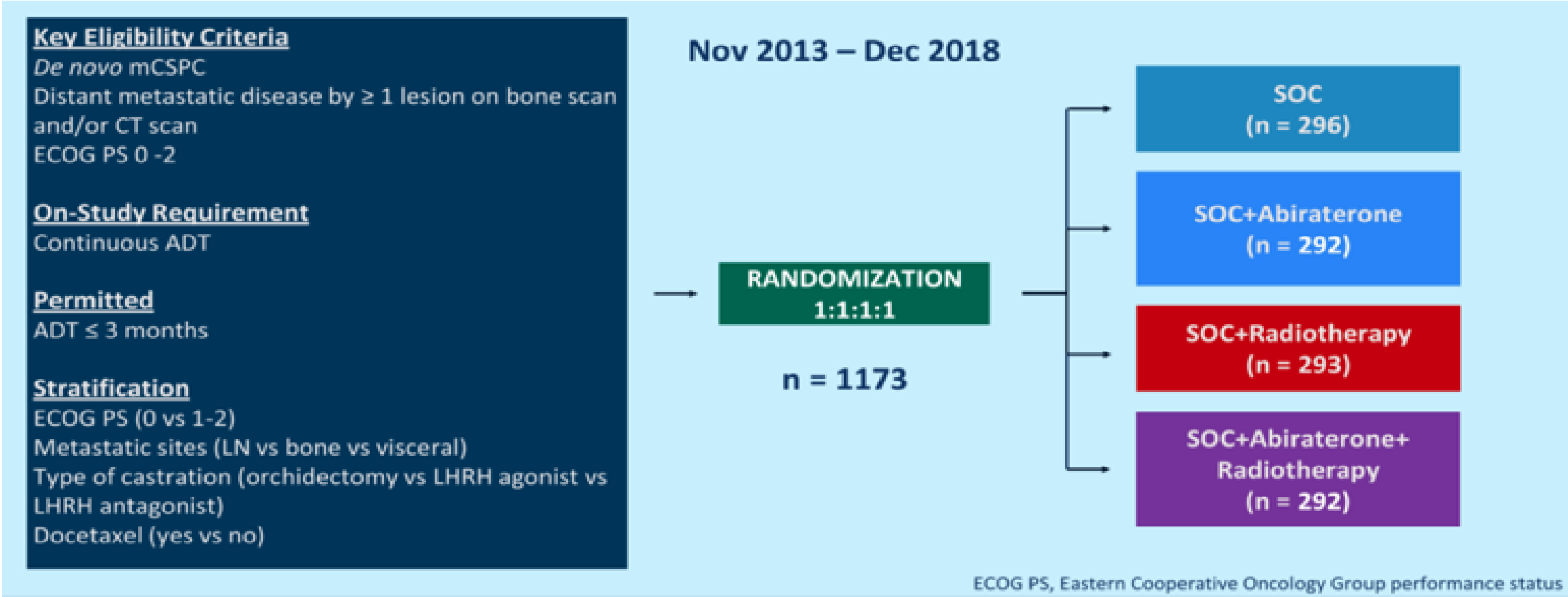




Woodcock Nat Com 2020, Pobel ESMO 2025

Abiraterone plus prednisone added to androgen deprivation therapy and docetaxel in de novo metastatic castration-sensitive prostate cancer (PEACE-1): a multicentre, open-label, randomised, phase 3 study with a 2 × 2 factorial design

*Karim Fizazi, Stéphanie Foulon, Joan Carles, Guilhem Roubaud, Ray McDermott, Aude Fléchon, Bertrand Tombal, Stéphane Supiot, Dominik Berthold, Philippe Ronchin, Gabriel Kacso, Gwenaëlle Gravis, Fabio Calabro, Jean-François Berdah, Ali Hasbini, Marlon Silva, Antoine Thiery-Vuillemin, Igor Latorzeff, Loïc Mourey, Brigitte Laguerre, Sophie Abadie-Lacourtoisie, Etienne Martin, Claude El Kouri, Anne Escande, Alvar Rosello, Nicolas Magne, Friederike Schlurmann, Frank Priou, Marie-Eve Chand-Fouche, Salvador Villà Freixa, Muhammad Jamaluddin, Isabelle Rieger, Alberto Bossi, on behalf of the PEACE-1 investigators**



ECOG PS, Eastern Cooperative Oncology Group performance status

Published Online April 8, 2022 https://doi.org/10.1016/ S0140-6736(22)00367-1

Abiraterone plus prednisone added to androgen deprivation therapy and docetaxel in de novo metastatic castration-sensitive prostate cancer (PEACE-1): a multicentre, open-label, randomised, phase 3 study with a 2 × 2 factorial design

		SOC (+/- RXT) (n = 589)	SOC (+/- RXT) + Abiraterone (n = 583)
Median age, year (IQR)		66 (59–72)	67 (61–72)
ECOG PS score, n (%)	0	412 (70)	412 (71)
	1-2	177 (30)	171 (29)
Gleason score at initial diagnosis, n (%)	≤ 7	132 (23)	144 (25)
	≥ 8	440 (77)	427 (75)
Median time from diagnosis, month (IQR)		2.3 (1.5-3.1)	2.3 (1.6-3.2)
Metastatic sites, n (%)	Lymph nodes only	52 (9)	47 (8)
	Bone without visceral	475 (81)	472 (81)
	Visceral	62 (11)	64 (11)
Disease burden, n (%)	Low	252 (43)	250 (43)
	High	334 (57)	330 (57)
Median baseline PSA, ng/mL (IQR)		11.4 (3.1-55.3)	14.2 (3.2-62.1)
Docetaxel, n (%)	Yes	355 (60)	355 (61)
	No	234 (40)	228 (39)

Published Online April 8, 2022 https://doi.org/10.1016/ S0140-6736(22)00367-1

Treatments

STANDARD of CARE treatments

Androgen Deprivation Therapy (ADT) continuously (LHRH agonist/antagonist or bilateral orchiectomy)

+/- Docetaxel 75 mg/m^2/3w x 6 (G-CSF recommended)

EXPERIMENTAL treatments

Abiraterone 1000 mg/d + Prednisone 5 mg BID until disease progression or intolerance (concomitant to docetaxel)

Radiotherapy (RXT) of the prostate 74 Gy in 37 fractions (after docetaxel is completed)

Endpoints

Co-primary

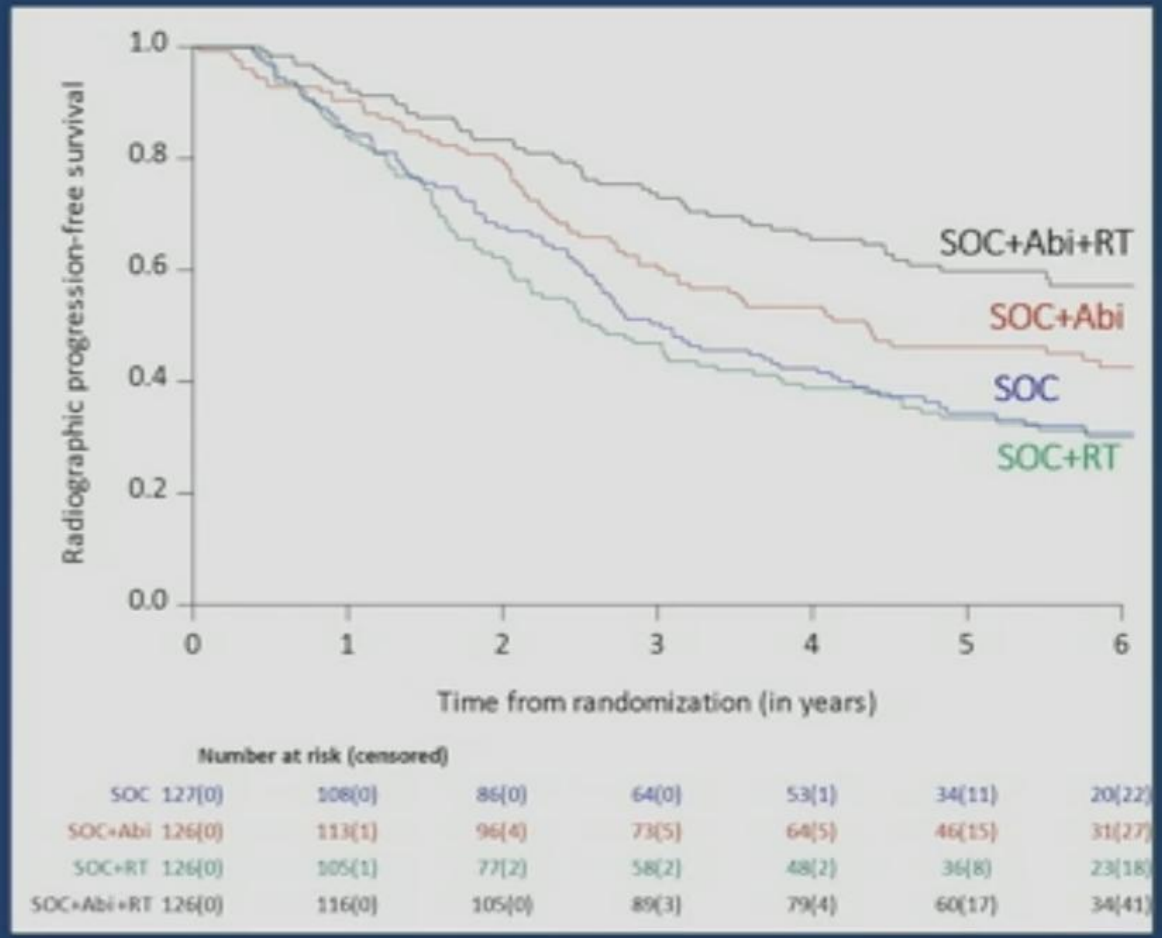
- Radiographic progression-free survival (rPFS):
  - PCWG2 criteria
  - Imaging at least q6m after PSA rise
- Overall survival (OS)

Secondary

- Castration resistance-free survival
- Serious genitourinary event-free survival
- Prostate cancer specific survival
- Time to next skeletal-related event
- PSA response rate
- PSA at 8 months after initation of SOC
- Time to pain progression
- Time to chemotherapy for CRPC
- Quality of life
- Toxicity
- Changes in bone mineral density (BMD)
- Biomarkers
- Outcomes for pts with NE differentiation

PSA: prostate-specific antigen; CRPC: Castration-resistant prostate cancer; NE: Neuro-endocrine

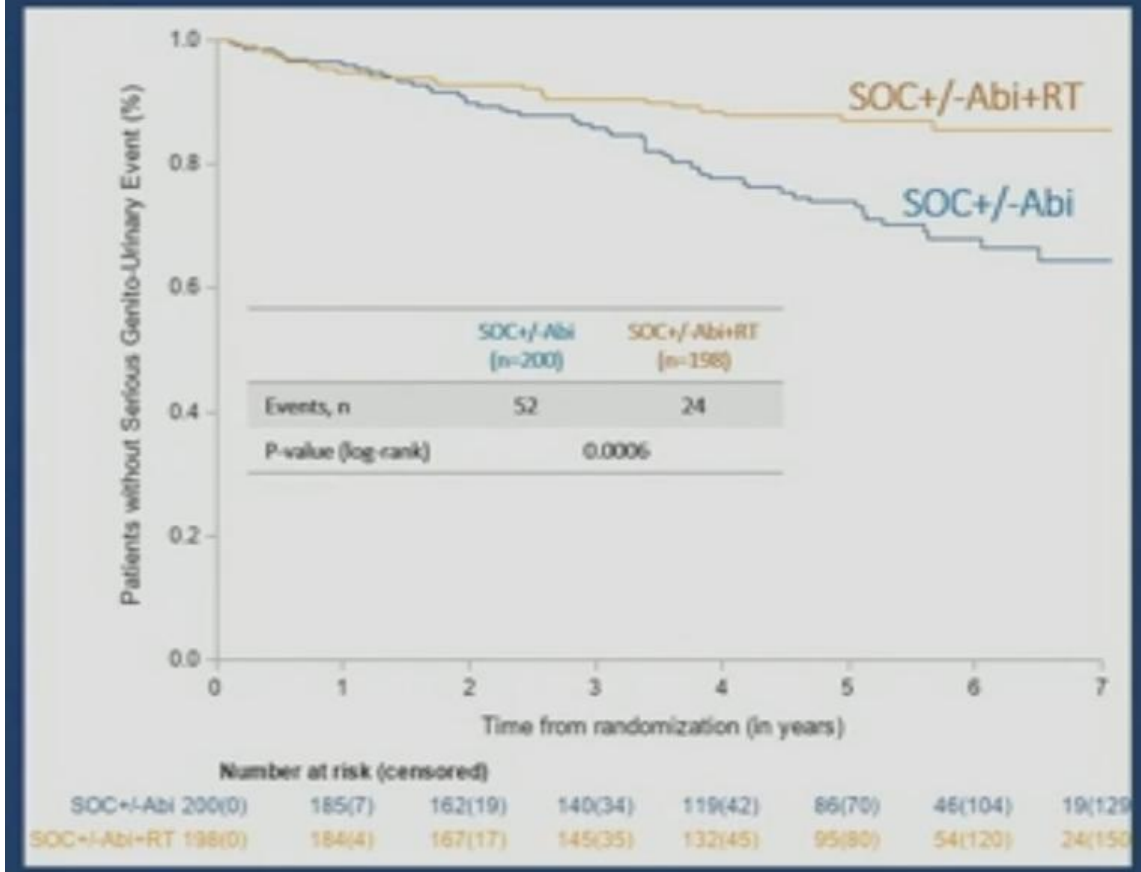
rPFS (low volume population)

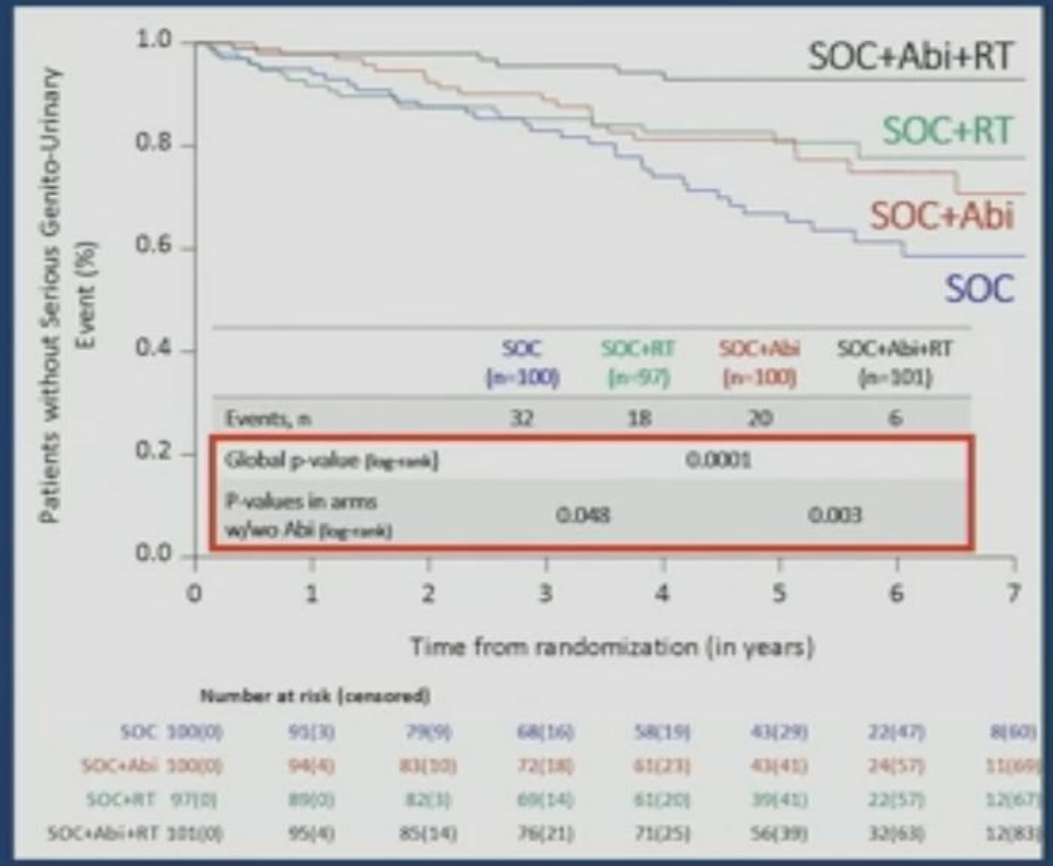


	SOC (n=127)	SOC+RT (n=126)	SOC+Abi (n=126)	SOC+Abi+RT (n=126)
Median, ys. (99.9% CI)	3.0 (2.3-4.8)	2.6 (1.7-4.6)	4.4 (2.5-7.3)	7.5 (4,0-NE)
Events, n.	87	89	74	55
HR (99.9%CI)*	Ref	1.11 (0.67-1.84)	0.76 (0.45-1,28)	0.50 (0.28-0.88)
Global p-value	<0.0001			
HR (99.9% CI)*	Ref	1.08 (0.65-1.80)	Ref	0.65 (0.36-1.19)
P-values arms w/wo Abi	0.61		0.02	

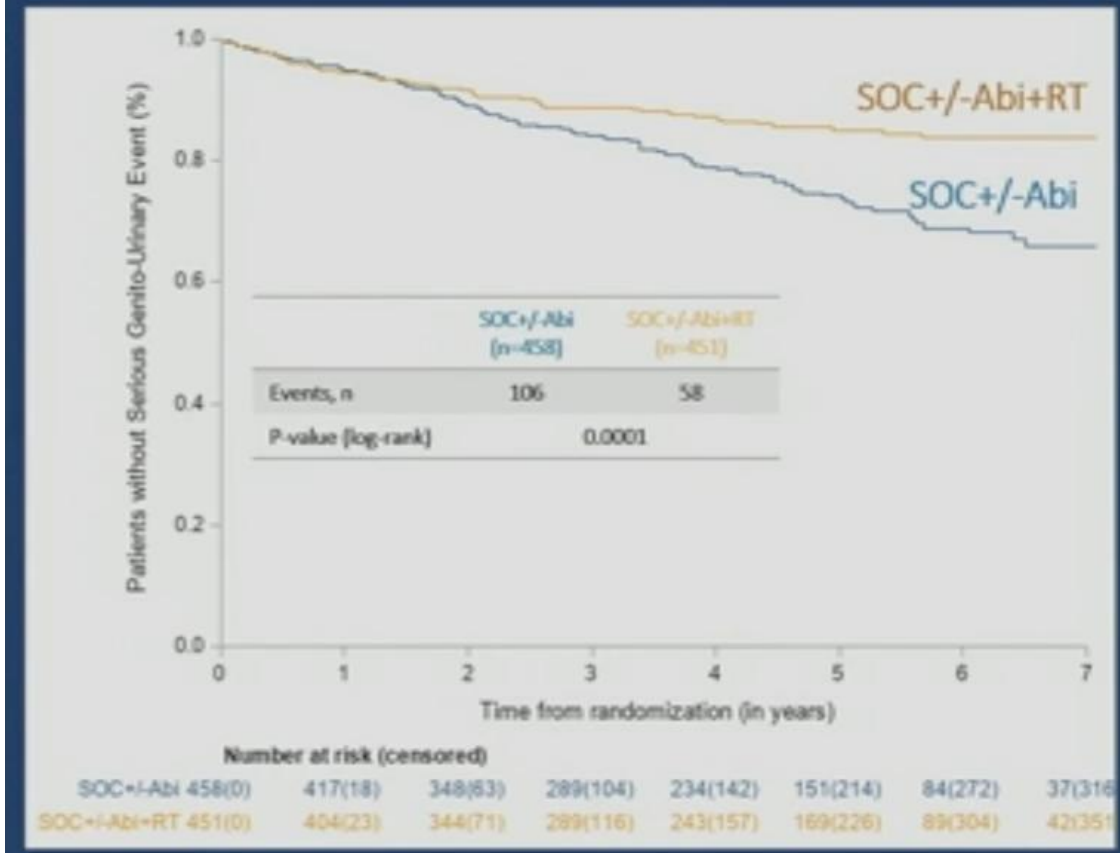
*Adjusted on stratification factors (PS, type of castration, docetaxel)

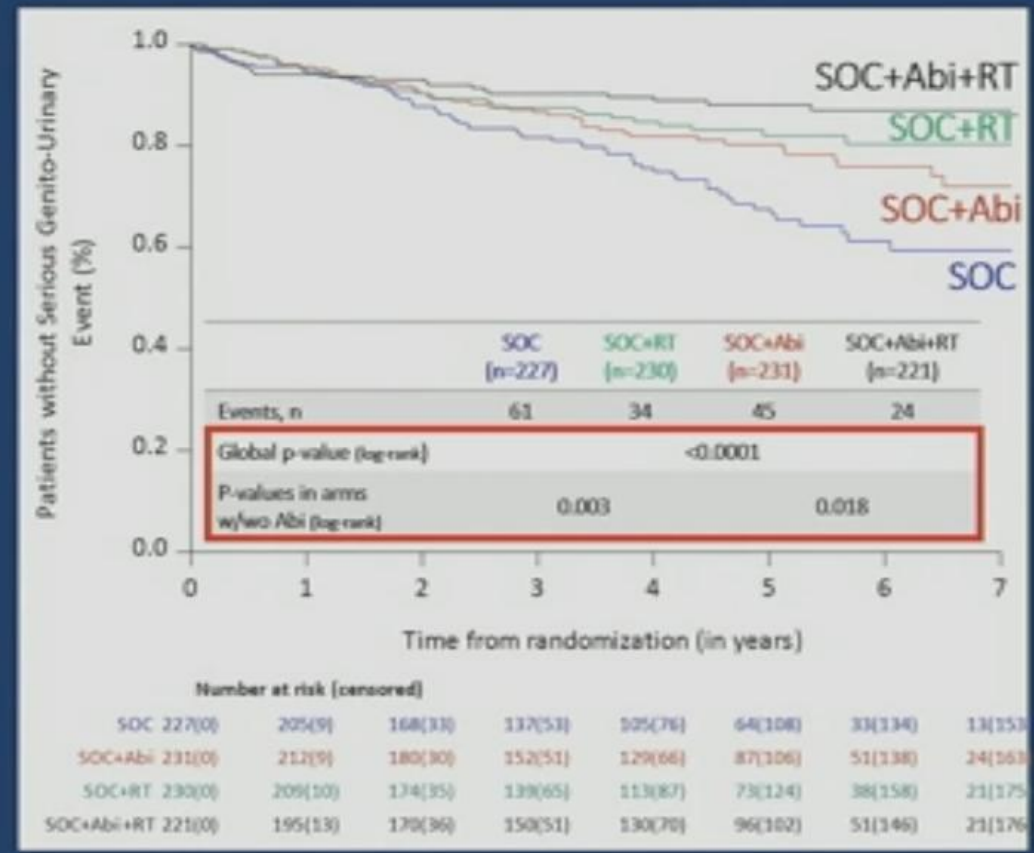
Time to Serious Genito-Urinary events (low volume pop.)





Time to Serious Genito-Urinary events (overall pop.)



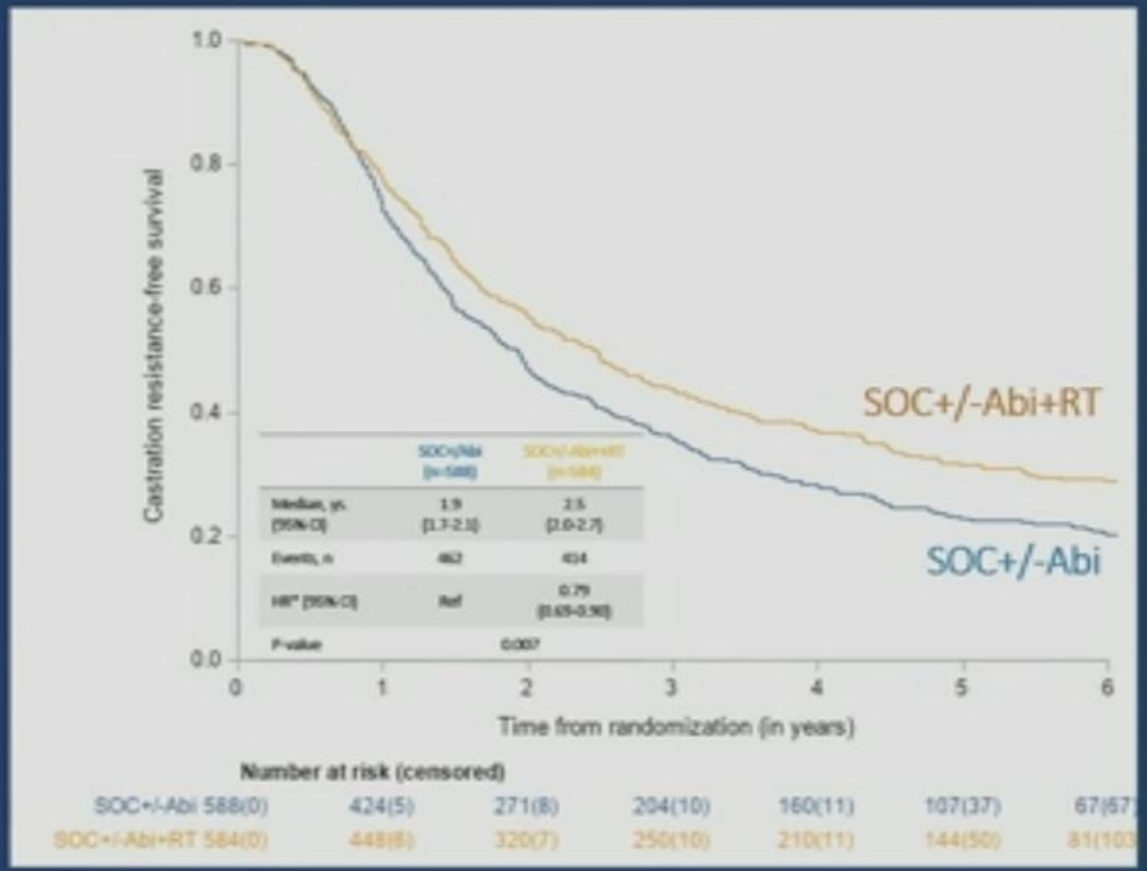


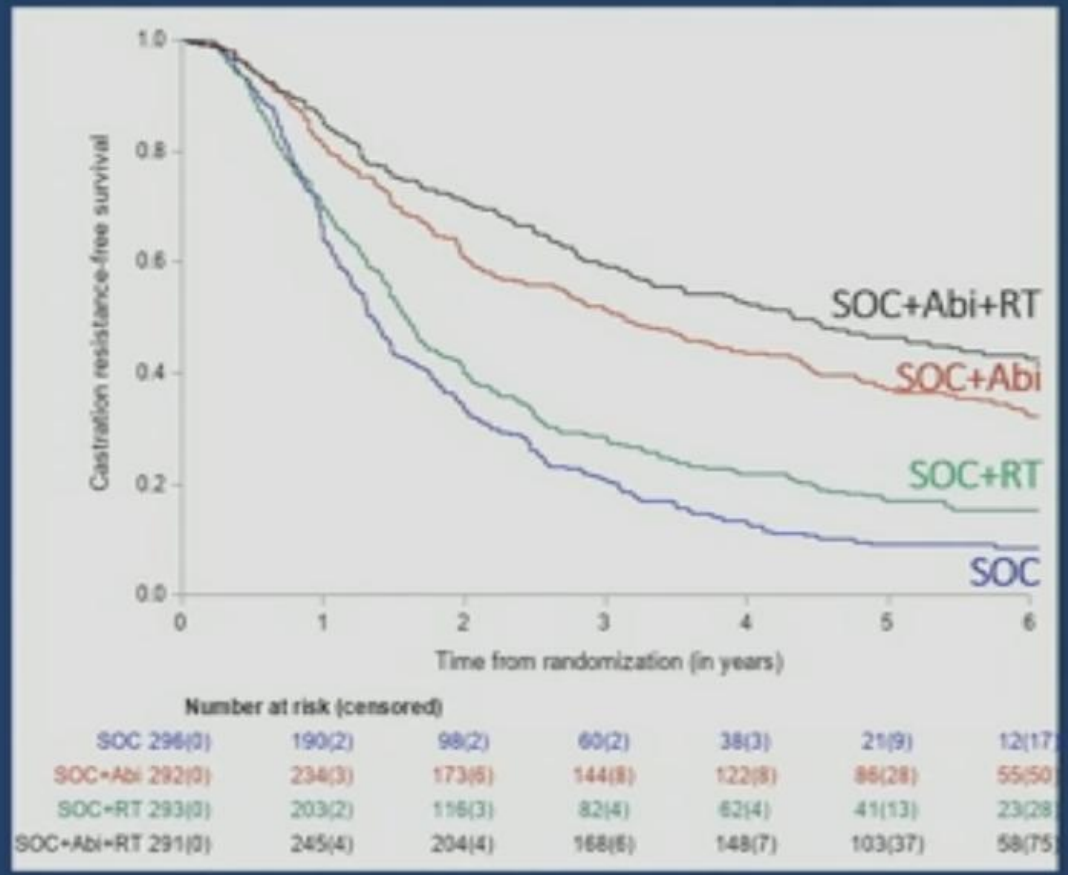
Serious Genito-Urinary events (low volume population*)

	No RT (n=200)	RT (n=198)
Urinary Catheter	9	6
Double J Stent	13	12
Nephrostomy	2	1
Prostate RT or TURP	27	4 TURP (all RT)
Radical Prostatectomy	1	1

*with available data regarding Serious Genito-Urinary events

Castration Resistance Free-Survival (overall pop.)





interaction p-value = 0.95

*Adjusted on abiraterone and stratification factors (PS, type of castration, docetaxel and burden)

NCCN Guidelines Version 3.2026
Prostate Cancer

PRINCIPLES OF RADIATION THERAPY

RT in Advanced Disease:

- **Synchronous mCSPC**
  - **Treatment of the primary tumor:**
    - **Minimizing toxicity is paramount when delivering RT to the primary tumor in patients with metastatic disease. As such, it is unclear if dose escalation (ie, brachytherapy or focal boost) improves outcomes.**
    - **Low Volume: Treatment of the primary is recommended with EBRT.[26,27]**
      - **Volume of disease should be defined according to CT and bone scan, if performed.**
      - **PET imaging should not be used to exclude a patient from treatment of the primary tumor.**
      - **The strongest data for a benefit of adding RT to the primary tumor are in patients receiving either ADT alone, ADT+ docetaxel, or ADT + abiraterone for those with ≤5 bony metastases.**
    - **High Volume: Treatment of the primary tumor with EBRT can be considered for select patients with high-volume mCSPC (category 2B).[27]**
      - **RT to the primary tumor in high volume mCSPC has demonstrated improvements in time to mCRPC and a reduction in the development of severe genitourinary adverse events when given in the context of ADT with variable use of docetaxel and/or abiraterone.**

EBRT Regimen	Preferred Dose/Fraction	Advanced Disease	
		Primary Tumor	Metastases
		mCSPC M0 CRPC mCRPC	MDT
Conventional	1.8–2 Gy x 37–45 fx	☼	
	1.8–2 Gy x 30–39 fx	☼	
Moderate Hypofractionation	3 Gy x 20 fx (preferred)[a] 2.7 Gy x 26 fx 2.5 Gy x 28 fx	☼	☼
	2.63–2.75 Gy x 20 fx 2.5 Gy x 25 fx	✓	☼
Ultra Hypofractionation (SBRT)	9.5 Gy x 4 fx 7.25–8 Gy x 5 fx 6 Gy x 6 fx 6.1 Gy x 7 fx	✓	✓
	9–10 Gy x 3 fx 12 Gy x 2 fx 16–24 Gy x 1 fx		✓
	6.2–6.4 Gy x 5 fx		
EBRT Boost Techniques			
EBRT with simultaneous integrated boost	See footnote b.	☼	
EBRT with sequential SBRT boost	*Prostate:* 1.8 Gy x 23–28 fx *Boost:* 6 Gy x 3 fx 9.5 Gy x 2 fx		

National Comprehensive Cancer Network®

RADIOTERAPIA DIRIGIDA A LA METASTASIS (MDT)

PRINCIPLES OF METASTASIS-DIRECTED THERAPY (MDT)

Number of Metastatic Sites

- The number of metastatic sites to define oligometastatic disease remains an evolving space and is impacted by sensitivity of imaging used. Early studies limited metastatic sites to 1–3 or 1–5 by CT, MRI, or bone scan.[1-4] More recent studies have included up to 10 metastatic sites by PSMA-PET imaging (NCT04787744, NCT06150417, NCT03721341). The upper limit is not clearly established and is both a function of oncologic limitations and technical limitations of treating numerous metastatic sites.
  - If CT, MRI, or bone scan is used, >5 metastasis is generally an exclusion for MDT.
  - If PSMA-PET is used, >10 metastatic sites is generally an exclusion for MDT.
- Lymph nodes in the same drainage chain (eg, two adjacent para-aortic lymph nodes) are to be considered 1 metastatic site and would be treated together with one radiation therapy isocenter or plan.
- Discrete, non-contiguous bony metastases should be counted separately even if treated with one isocenter (eg, two discrete femur metastases).
- The goal of MDT is generally to treat all metastatic sites, which may include regional lymph nodes and potentially treatment of the primary tumor if untreated or evidence of local recurrence. The primary tumor in this setting should be counted as a site.

Location of Metastatic Sites

- The location of metastatic sites have generally consisted of lymph node and osseous metastatic sites, but some studies include lung and liver metastases. Brain metastases are generally not included in studies of MDRT in prostate cancer. MDT should not be used to delay systemic therapy when there is visceral organ involvement.
- Pelvic lymph nodes are also considered metastatic sites in the context of MDRT for metachronous mCSPC or mCRPC.

Table 1.

Treatment Regimen	mCSPC		mCRPC	
	Synchronous (de novo) Oligometastatic	Metachronous Oligorecurrent[a]	Oligometastatic	Oligoprogressive
MDT	☼	✓	✓	☼

(✓ Preferred; ☼ Acceptable based on clinical and medical need)

Fuente: NCT04787744

Reclutamiento

VA STARPORT: Veterans Affairs Seamless Phase II/III Randomized Trial of STAndard Systemic theRapy With or Without PET-directed Local Therapy for Oligometastatic pRosTate Cancer

Intervencionista · Fase 2/3 · VA Ann Arbor Healthcare System, Ann Arbor, MI

This is a prospective, open-label, multi-center seamless phase II to phase III randomized clinical trial designed to compare SST with or without PET-directed local therapy in improving the castration-resistant prostate cancer-free survival (CRPC-free survival) for Veterans with oligometastatic prostate cancer. Oligometastasis will be defined as 1-10 sites of metastatic disease based on the clinical determination of the LSI which incorporates all imaging, clinical, and pathologic data

Recruiting

MDRT in Prostate Cancer Treated With Long-term Androgen Deprivation Therapy in the STAMPEDE Trial (METANOVA)

ClinicalTrials.gov ID NCT06150417

Sponsor Case Comprehensive Cancer Center

Information provided by Case Comprehensive Cancer Center (Responsible Party)

Last Update Posted 2025-09-12

Active, not recruiting

Stereotactic Ablative Radiotherapy for Comprehensive Treatment of 4-10 Oligometastatic Tumors (SABR-COMET 10)

ClinicalTrials.gov ID NCT03721341

Sponsor David Palma

Information provided by David Palma, London Health Sciences Centre Research Institute OR Lawson Research Institute of St. Joseph's (Responsible Party)

Last Update Posted 2025-09-18

The Metastatic Burden in Available RCTs has Always Been Assessed Using Conventional Imaging Techniques

6.4 Treatment: Metastatic prostate cancer

6.4.1 ***Introduction***

All prospective data available rely on the definition of M1 disease based on CT scan and bone scan. The influence on treatment and outcome of newer, more sensitive, imaging has not been assessed yet.

Hormone-sensitive metastatic PCa

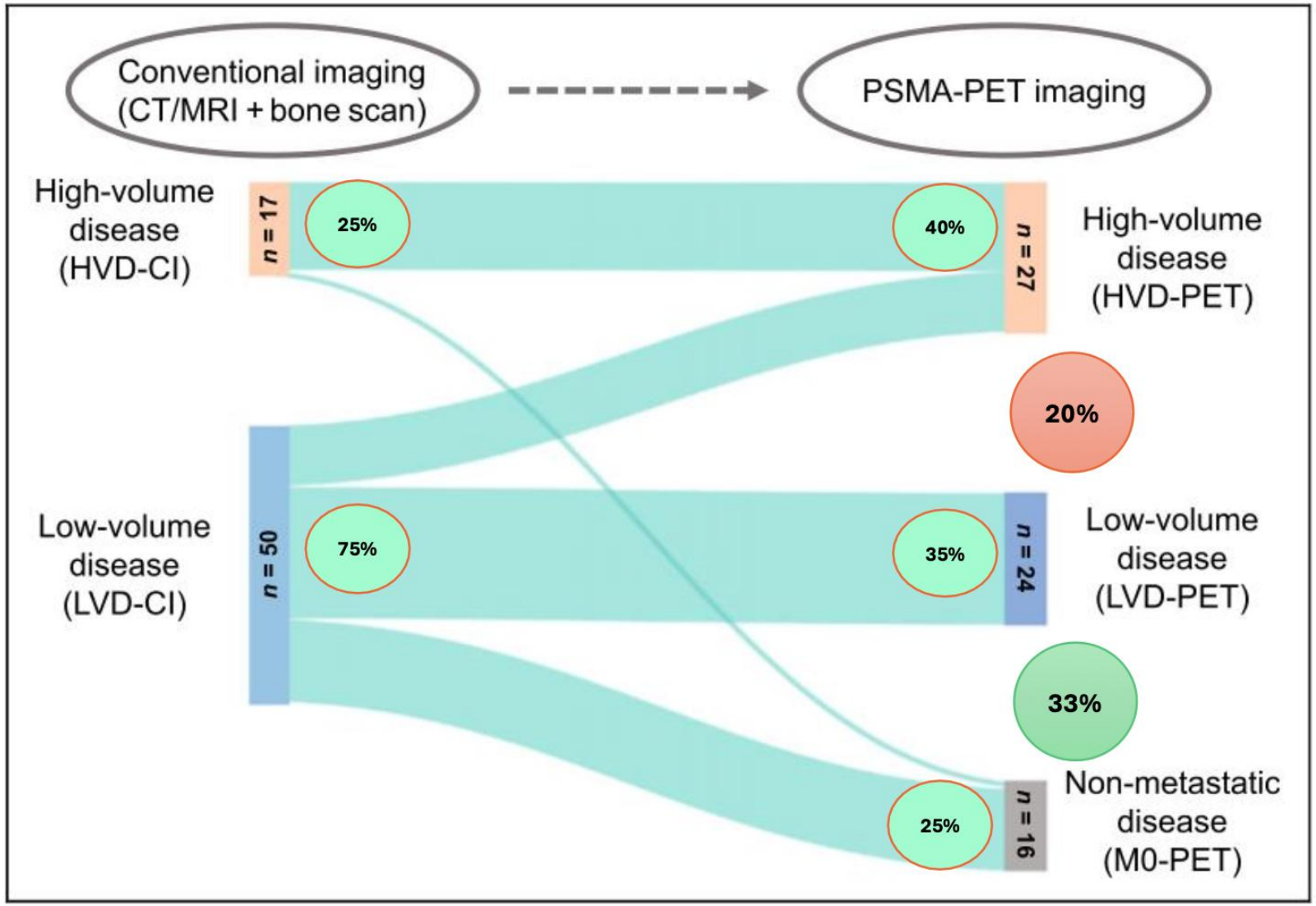
Study	Treatment	CT scan	Bone Scan	PET/CT
STAMPEDE	Docetaxel Abiraterone			
CHARTEED	Docetaxel			
LATITUDE	Abiraterone			
ENZAMET	Enzalutamide			
ARCHES	Enzalutamide			
TITAN	Apalutamide			
ARASENS	Darolutamide			
CHART	Rezvilutamide			

Oligometastatic PCa

Study	Treatment	CT scan	Bone Scan	PET/CT
PEACE-1 NCT01957436	ADT vs. ADT + RT			
NCT01751438 M.D. Anderson Cancer Center, USA	ADT vs. RP + ADT			
STAMPEDE	ADT vs. ADT + RT			
HORRAD	ADT vs. ADT + RT			

Low- and High-Volume Disease in Metastatic Hormone-Sensitive Prostate Cancer: From CHAARTED to PSMA PET—An International Multicenter Retrospective Study

Lena M. Unterrainer[1–3], Thomas A. Hope[4], Wolfgang P. Fendler[5,6], Tristan Grogan[7], Honest Ndlovu[8], Wesley Armstrong[1], Francesco Barbato[5,6], Matthias R. Benz[1,9], Matthew B. Rettig[10,11], Amar U. Kishan[11,12], Mike Sathekge[8], Ken Herrmann[5,6], Johannes Czernin[1], and Jeremie Calais[1]

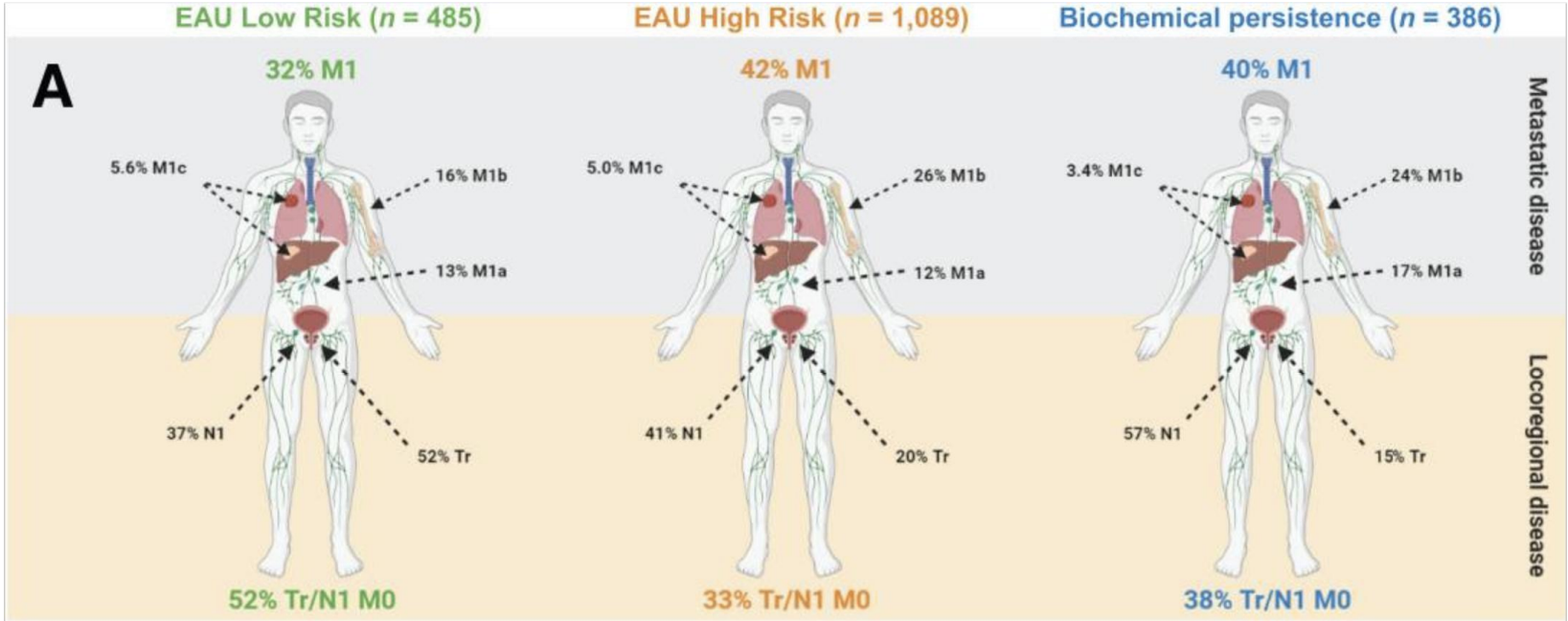


J Nucl Med 2025; 66:54–60 DOI: 10.2967/jnumed.124.268441

PSMA PET Validates Higher Rates of Metastatic Disease for European Association of Urology Biochemical Recurrence Risk Groups: An International Multicenter Study

Justin Ferdinandus [1,*], Wolfgang P Fendler [1,2,*,✉], Andrea Farolfi [1,3], Samuel Washington [4,5], Osama Mohamad [6],

***N* = 1,960 included in final analysis**



Category	group	no. M0 (%)	no. M1 (%)	OR (CI95)	*P*
Initial therapy	prostatectomy	954 (79.6)	539 (70.7)	Reference	
	radiotherapy	244 (20.4)	223 (29.3)	1.08 (0.79-1.49)	*P* = 0.612
PSA	< 0.5 ng/ml	366 (30.6)	70 (9.2)	Reference	
	≥ 0.5 to < 1.0 ng/ml	276 (23.0)	123 (16.1)	2.24 (1.59-3.17)	*P* < 0.001
	≥ 1.0 to < 2.0 ng/ml	154 (12.9)	95 (12.5)	3.17 (2.21-4.58)	*P* < 0.001
	≥ 2.0 to < 5.0 ng/ml	236 (19.7)	194 (25.5)	5.56 (3.96-7.87)	*P* < 0.001
	≥ 5.0 ng/ml	166 (13.9)	280 (36.7)	12.16 (8.52-17.55)	*P* < 0.001
Risk group	EAU low risk	329 (27.5)	156 (20.5)	Reference	
	EAU high risk	637 (53.2)	452 (59.3)	2.91 (2.18-3.93)	*P* < 0.001
	Biochemical Persistence	232 (19.4)	154 (20.2)	3.08 (2.12-4.48)	*P* < 0.001

J Nucl Med. 2022 Jan;63(1):76–80. doi: 10.2967/jnumed.121.262821

RADIOTERAPIA DIRIGIDA A LA METASTASIS (MDT)

OLIGOMETASTASICO DE NOVO

?

OLIGOMETASTASICO METACRONICO O RECURRENTE

OLIGOPROGRESION RESISTENTE A LA CASTRACION

?

Table 5 Clinical Trials for OMD with Prostate Cancer

Author (year)	N	OMD type	Number of lesions	Design	Primary endpoint	Local treatment	Dose fractionation	RT prescription	Main result
Ost et al (2017) [41] STOMP trial	62	Mixed OMD	≤ 3 lesions	Randomized phase II MDT vs surveillance	ADT-free survival		30 Gy/3 fx	PTV D90%, 80%_ isodose	tThe median ADT-free survival: MDT 21 months vs surveillance 13 months (HR, 0.60 [80% CI 0.40–0.90]; p = 0.11)
Siva et al (2018) [42] POPSTAR trial	33	Mixed OMD	≤ 3 lesions	Phase II Single arm: SBRT	Feasibility and tolerability	SBRT	20 Gy/1fx	PTV D95%, 80%_ isodose	SABR was feasible in 97% of cases. Grade 3 AE: 3.0% The 2-yr LPFS: 93% (95% CI 84–100), The 2-yr DPFS 39% (95% CI 25–60)
Philips et al. (2020) ORIOLE trial [43]	54	Metachronous OMD	≤ 3 lesions < 5.0 cm	Randomized phase II SBRT vs observation	Disease progression at 6 months	SBRT	19.5–48.0 Gy/3–5fx	NA	Progression at 6 months: SBRT 19% vs observation 61% (p = 0.005) PFS: not reached vs 5.8 months; HR 0.30 (95% CI 0.11–0.81, p = 0.002)
Bowden et al. (2020) [44]	199	Mixed OMD	≤ 5 lesions	Phase II Single arm: SBRT	Treatment escalation	SBRT	50 Gy/10 fx	90% of dose (45 Gy) covering PTV	The proportion of patients not requiring treatment escalation 2 years: 51.7% (95% CI 44.1–59.3%)
Glicksman et al. (2020) PSMA-MRgRT trial [45]	72	Metachronous OMD	Not pre-defined (PSMA PET-defined oligometastases)	Single-arm phase II	Biochemical response	SBRT or surgery	27–30 Gy/3 fx	NA	The overall response rate: 60% The median time to PSA progression:17.7 months (95% CI 11.0–not reached) One grade 3 toxicity (2.7%))

OMD oligometastatic disease, *PSMA PET* prostate-specific membrane antigen positron emission tomography, *MDT* metastasis-directed therapy, *SBRT* stereotactic body radiotherapy, *ADT* androgen deprivation therapy, *PTV* planning target volume, *HR* hazard ratio, *CI* confidence interval, *LPFS* local progression-free survival, *DPFS* distant progression-free survival, *PFS* progression-free survival, *PSA* prostate-specific antigen, *NA* Not Available

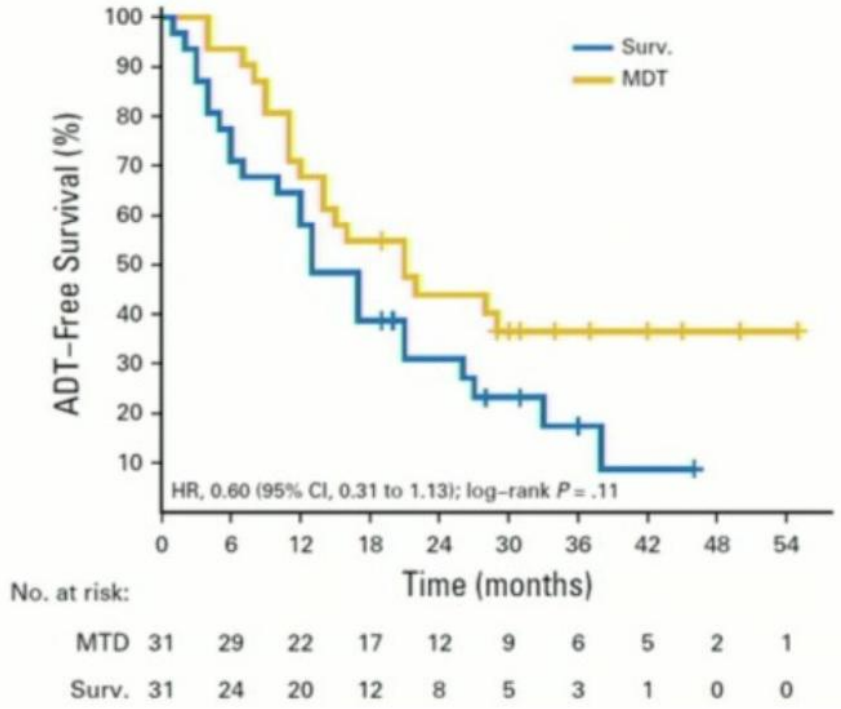
Table 2 (continued)

Trial Name	Design	Primary Cancer	OMD type	OMD Definition	SBRT Regimen	Planned Enrollment	Primary Endpoint	Estimated Completion
OLIGOMA	Phase III	Breast	Oligorecurrence	≤ 5 lesions (no brain)	SBRT + SOC	564	PFS	2030–08
TAORMINA	Phase III	Breast	Recurrent or stage IV	Recurrent/ stage IV	SBRT vs SOC	345	PFS, OS	2026
START-MET	Phase III	Prostate	Synchronous or metachronous	≤ 3 mets (CT)/≤ 5 (PSMA PET)	SBRT + SOC	266	rPFS	2026–01
METRO	Phase III	Prostate	Synchronous or metachronous	≤ 5 mets (PSMA PET)	SBRT + SOC	118	FFS	2033–12
SPARKLE	Phase III	Prostate	Metachronous	≤ 5 mets (PSMA PET)	MDT ± ADT ± Enza	873	PolyMFS	2032–04
ECOG-ACRIN 8191 INDICATE	Phase III	Prostate	Postoperative recurrence	Post-op recurrence	SOC ± MDT	804	PFS	2032–12
OLIGOPELVIS2	Phase III	Prostate (nodal)	Oligorecurrent nodal	≤ 5 pelvic LN mets	IMRT + ADT	256	PFS	2026–01
PEACE V-STORM	Phase III	Prostate (nodal)	Oligorecurrent nodal	≤ 5 pelvic LN mets	SBRT/LND ± WPRT + ADT	196	PFS	2026–12

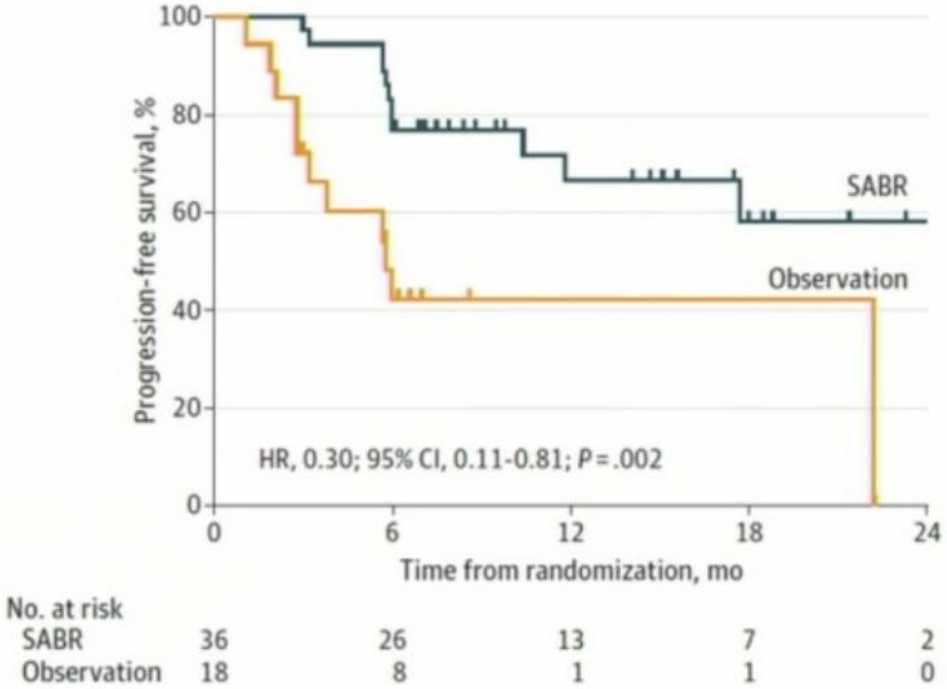
OMD oligometastatic disease, *SBRT* stereotactic body radiotherapy, *RT* radiotherapy, *TKI* tyrosine kinase inhibitor, *SOC* standard of care, *RT* radiotherapy, *PFS* progression-free survival, *OS* overall survival, *PSMA PET* prostate-specific membrane antigen positron emission tomography, *rPFS* radiographic progression-free survival, *FFS* failure-free survival, *MDT* metastasis-directed therapy, *ADT* androgen deprivation therapy, *Enz* enzalutamide, *PolyMFS* polymetastatic-free survival, *IMRT* intensity-modulated radiotherapy, *LND* lymph node dissection, *WPRT* whole pelvis radiotherapy

1. Phillips R, Shi WY, Deek MP, et al. "Outcomes of Observation vs Stereotactic Ablative Radiation for Oligometastatic Prostate Cancer: The ORIOLE Phase 2 Randomized Clinical Trial." *JAMA Oncology*. 2020;6(5):650–659
2. Ost P, Reynders D, Decaestecker K, et al. "Surveillance or Metastasis-Directed Therapy for Oligometastatic Prostate Cancer Recurrence: A Prospective, Randomized, Multicenter Phase II Trial." *Journal of Clinical Oncology*. 2018;36(5):446–453

STOMP

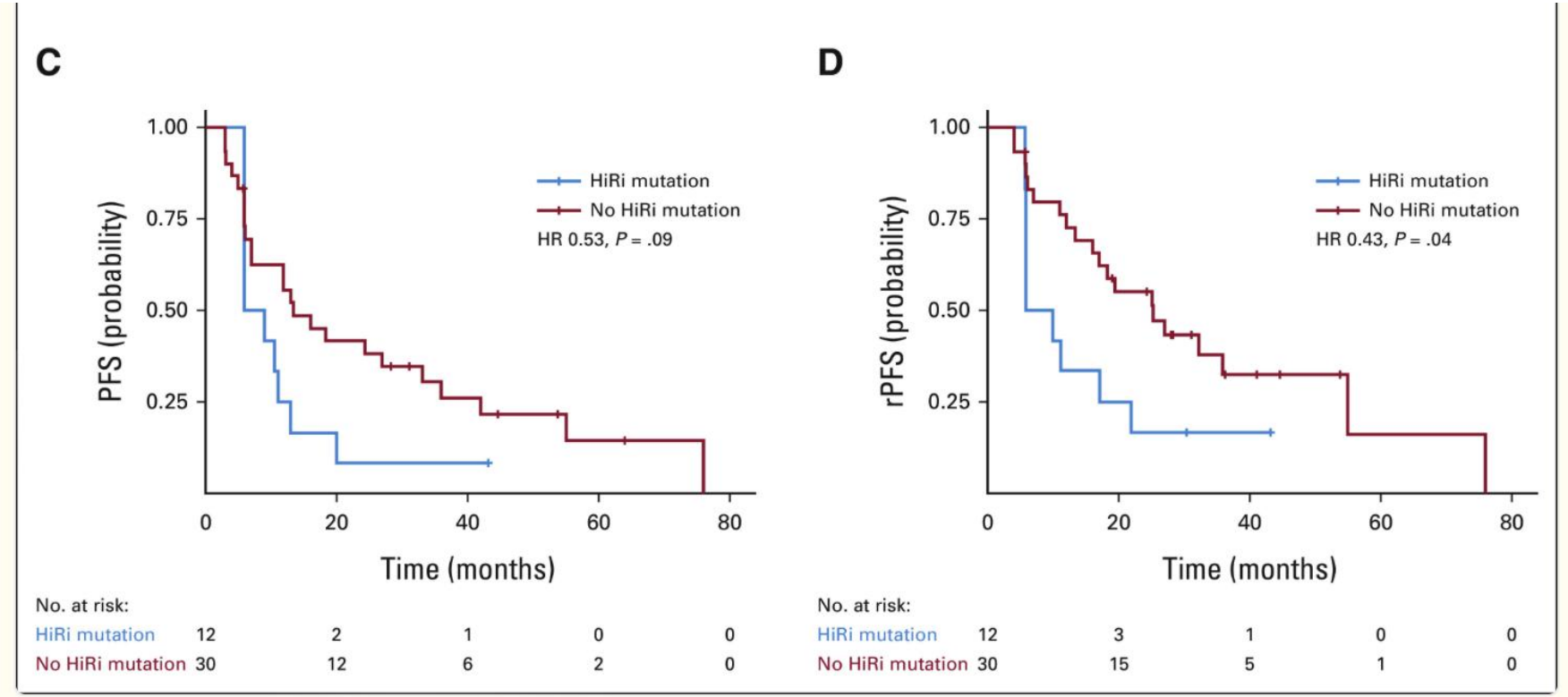


ORIOLE



Long-Term Outcomes and Genetic Predictors of Response to Metastasis-Directed Therapy Versus Observation in Oligometastatic Prostate Cancer: Analysis of STOMP and ORIOLE Trials

Matthew P Deek [1,2], Kim Van der Eecken [3], Philip Sutera [2], Rebecca A Deek [4], Valérie Fonteyne [5], Adrianna A Mendes

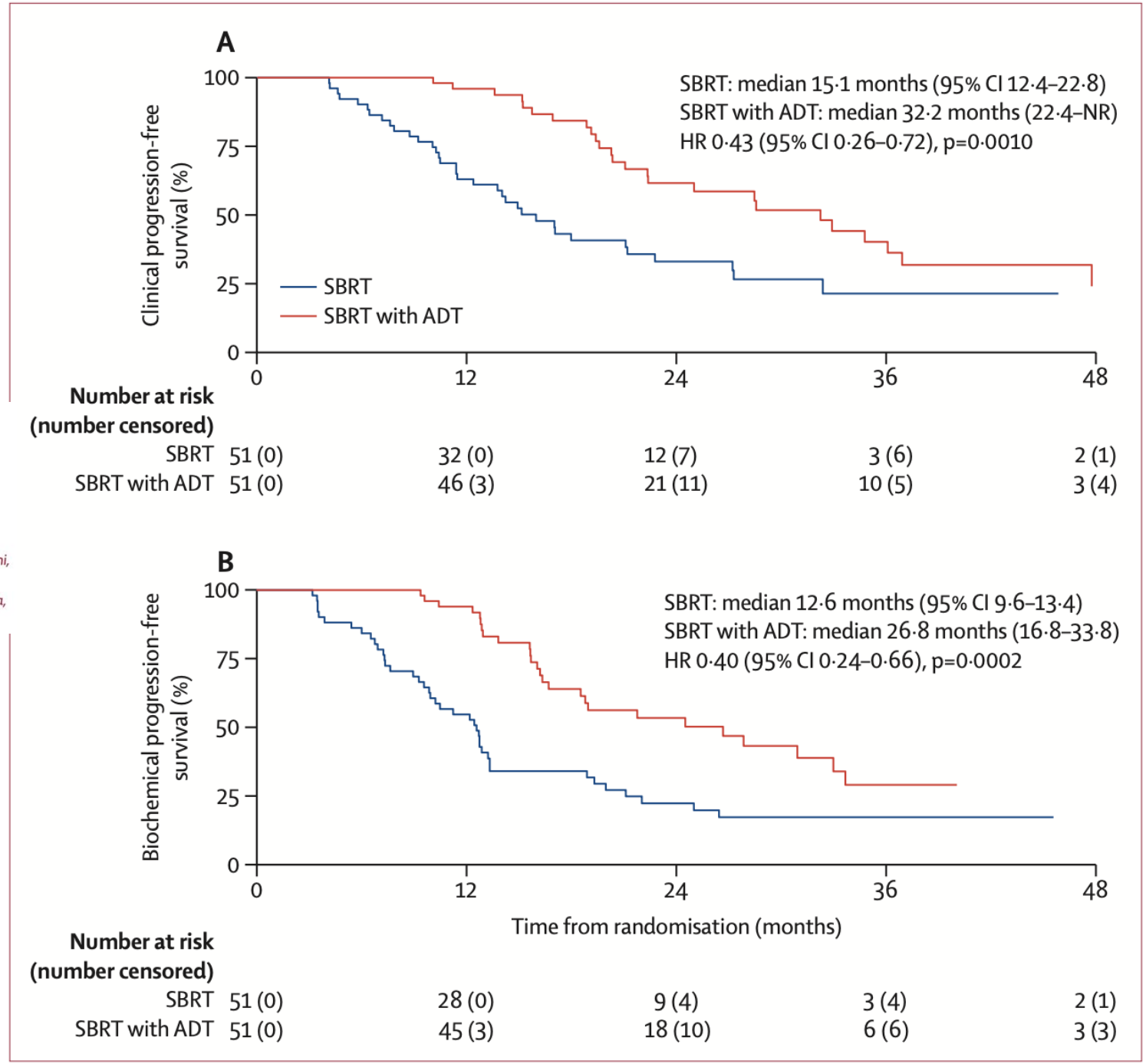


HiRi: mutational signature was *ATM*, *BRCA1/2*, *Rb1*, *TP53*

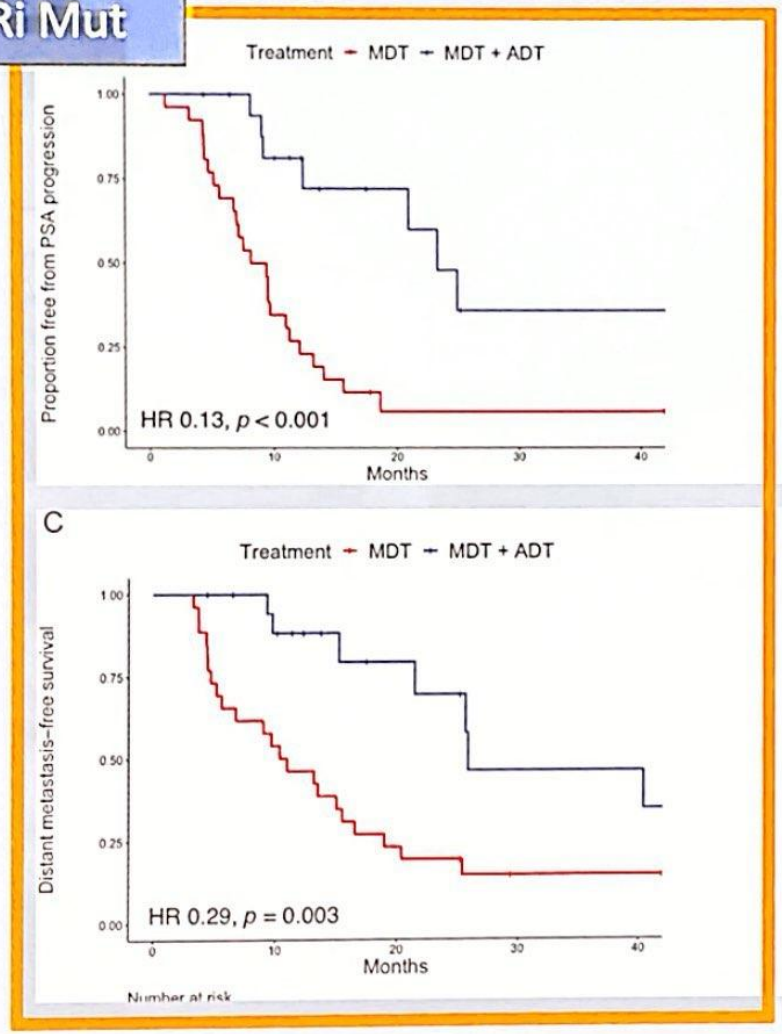
J Clin Oncol. 2022 Aug 24;40(29):3377–3382. doi: 10.1200/JCO.22.00644

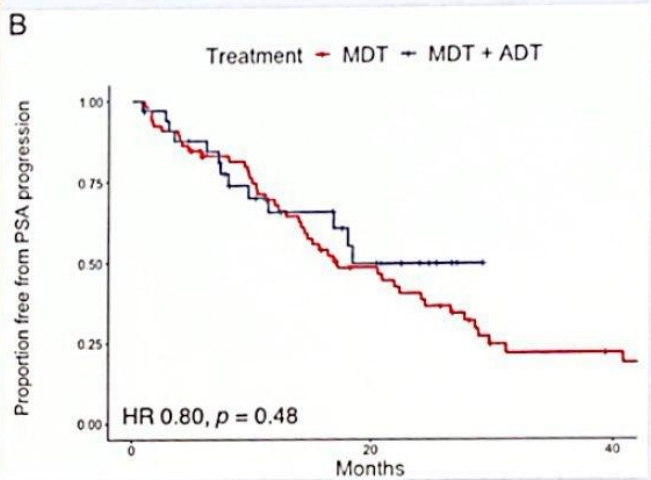
ADT with SBRT versus SBRT alone for hormone-sensitive oligorecurrent prostate cancer (RADIOSA): a randomised, open-label, phase 2 clinical trial

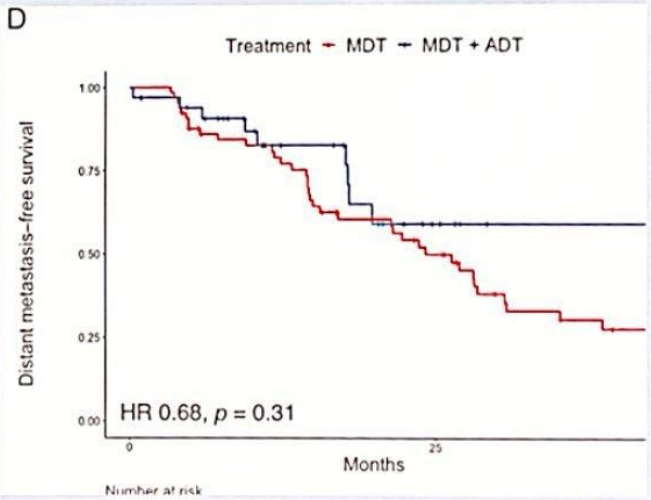
Giulia Marvaso, Giulia Corrao*, Mattia Zaffaroni, Maria Giulia Vincini, Chiara Lorubbio, Sara Gandini, Cristiana Fodor, Sofia Netti, Dario Zerini, Stefano Luzzago, Francesco Alessandro Mistretta, Konstantinos Venetis, Giulia Cursano, Tiziana Burla, Ketti Mazzocco, Federica Cattani, Giuseppe Petralia, Nicola Fusco, Gabriella Pravettoni, Gennaro Musi, Ottavio De Cobelli, Chad Tang, Piet Ost, David A Palma, Roberto Orecchia, Barbara Alicja Jereczek-Fossa*



HiRi Mut



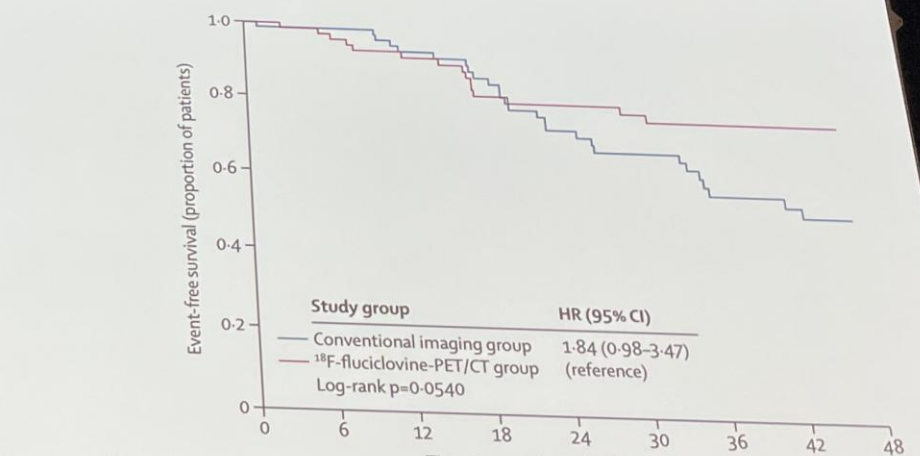




Sutera et al. Eur Urol 2025

Should We Perform Imaging or Immediate sRT?

- 3-year event-free survival was **63% in the conventional imaging group versus 75% for 18F-fluciclovine-PET/CT (p=0.0028)**
- In adjusted analyses, **study group (hazard ratio 2·04 p=0.0327) was significantly associated with event-free survival**
- Toxicity was similar in both study groups, with the most common adverse events being late urinary frequency or urgency (37 [46%] of 81 patients in the conventional imaging group and 31 [41%] of 76 in the PET group), and acute diarrhoea (11 [14%] in the conventional imaging group and 16 [21%] in the PET group)



Number at risk (number censored)									
Conventional imaging group	81 (1)	76 (4)	66 (13)	54 (21)	44 (22)	36 (25)	28 (31)	23 (33)	19 (54)
18F-fluciclovine-PET/CT group	76 (1)	71 (4)	59 (13)	53 (15)	46 (19)	41 (22)	35 (26)	30 (32)	21 (61)

Jani et al. Lancet 2021;397:1895

RADIOTERAPIA DIRIGIDA A LA METASTASIS (MDT)

OLIGOMETASTASICO DE NOVO

?

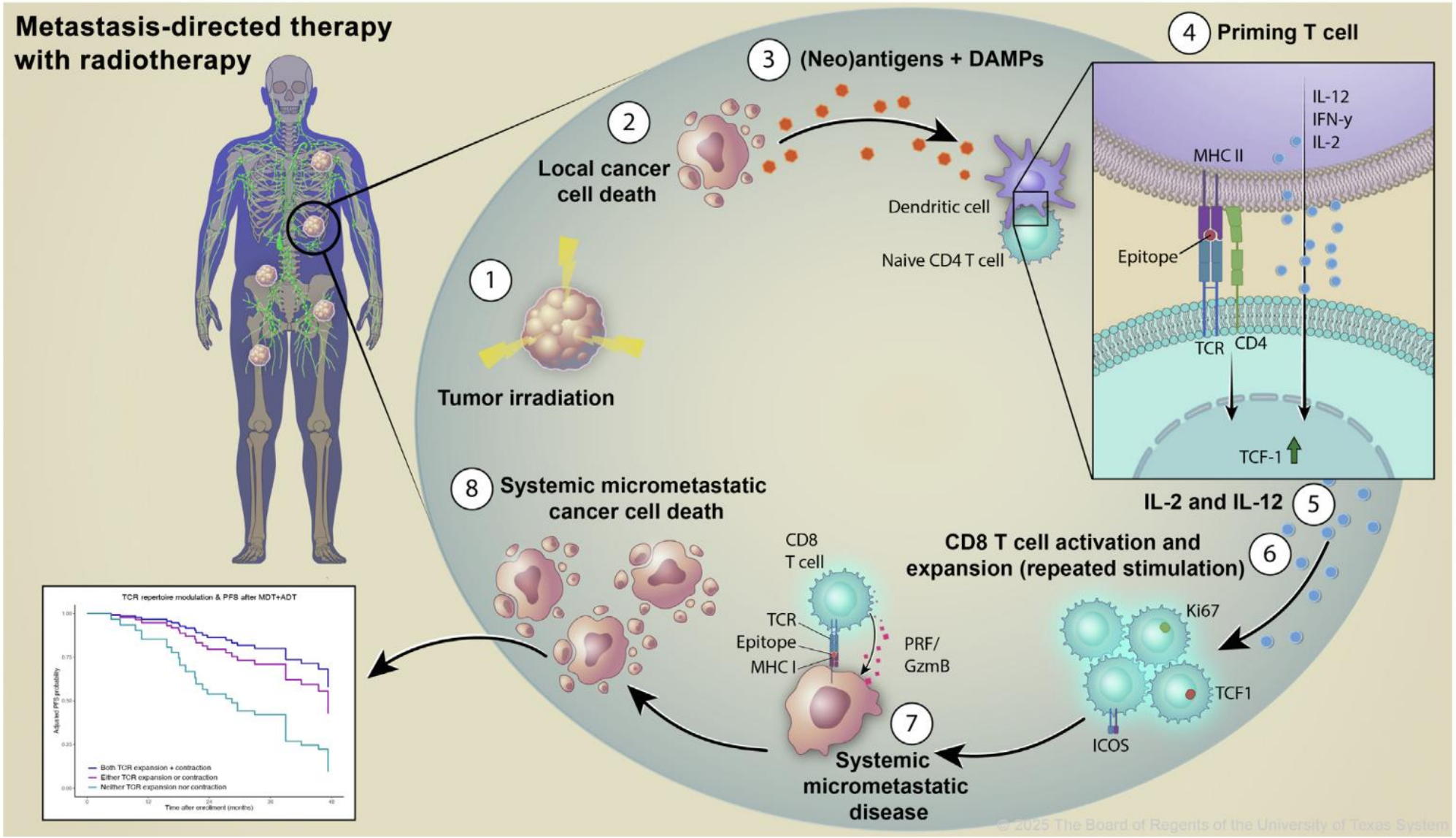
OLIGOMETASTASICO METACRONICO O RECURRENTE

OLIGOPROGRESION RESISTENTE A LA CASTRACION

?

Continuous Androgen Deprivation Therapy with or Without Metastasis-directed Therapy for Oligometastatic Prostate Cancer: The Multicenter Phase 2 Randomized EXTEND Trial

Alexander D. Sherry [a,j,*], *Bilal A. Siddiqui* [b,*], *Cara Haymaker* [c], *Bryan M. Fellman* [d],

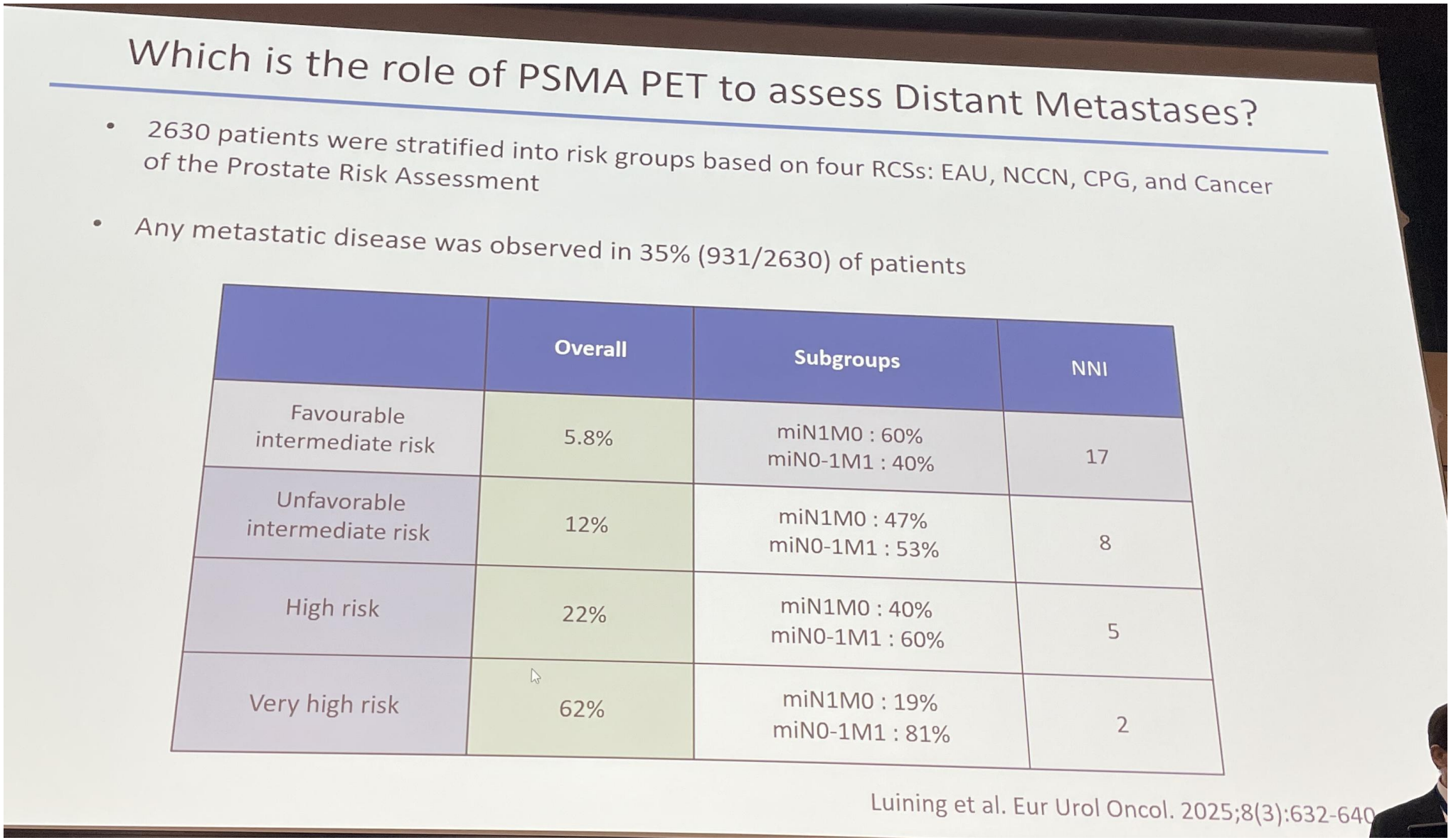


https://doi.org/10.1016/j.eururo.2025.07.006

European Association of Urology

A Comparison of Globally Applied Prognostic Risk Groups and the Prevalence of Metastatic Disease on Prostate-specific Membrane Antigen Positron Emission Tomography in Patients with Newly Diagnosed Prostate Cancer

Wietske I. Luining [a,b,c,], Liselotte M.S. Boevé [d], Marinus J. Hagens [a,c,e], Dennie Meijer [a,b,c],*



	Overall	Subgroups	NNI
Favourable intermediate risk	5.8%	miN1M0 : 60% miN0-1M1 : 40%	17
Unfavorable intermediate risk	12%	miN1M0 : 47% miN0-1M1 : 53%	8
High risk	22%	miN1M0 : 40% miN0-1M1 : 60%	5
Very high risk	62%	miN1M0 : 19% miN0-1M1 : 81%	2

Continuous Androgen Deprivation Therapy with or Without Metastasis-directed Therapy for Oligometastatic Prostate Cancer: The Multicenter Phase 2 Randomized EXTEND Trial

Alexander D. Sherry [a,j,*], *Bilal A. Siddiqui* [b,*], *Cara Haymaker* [c], *Bryan M. Fellman* [d],

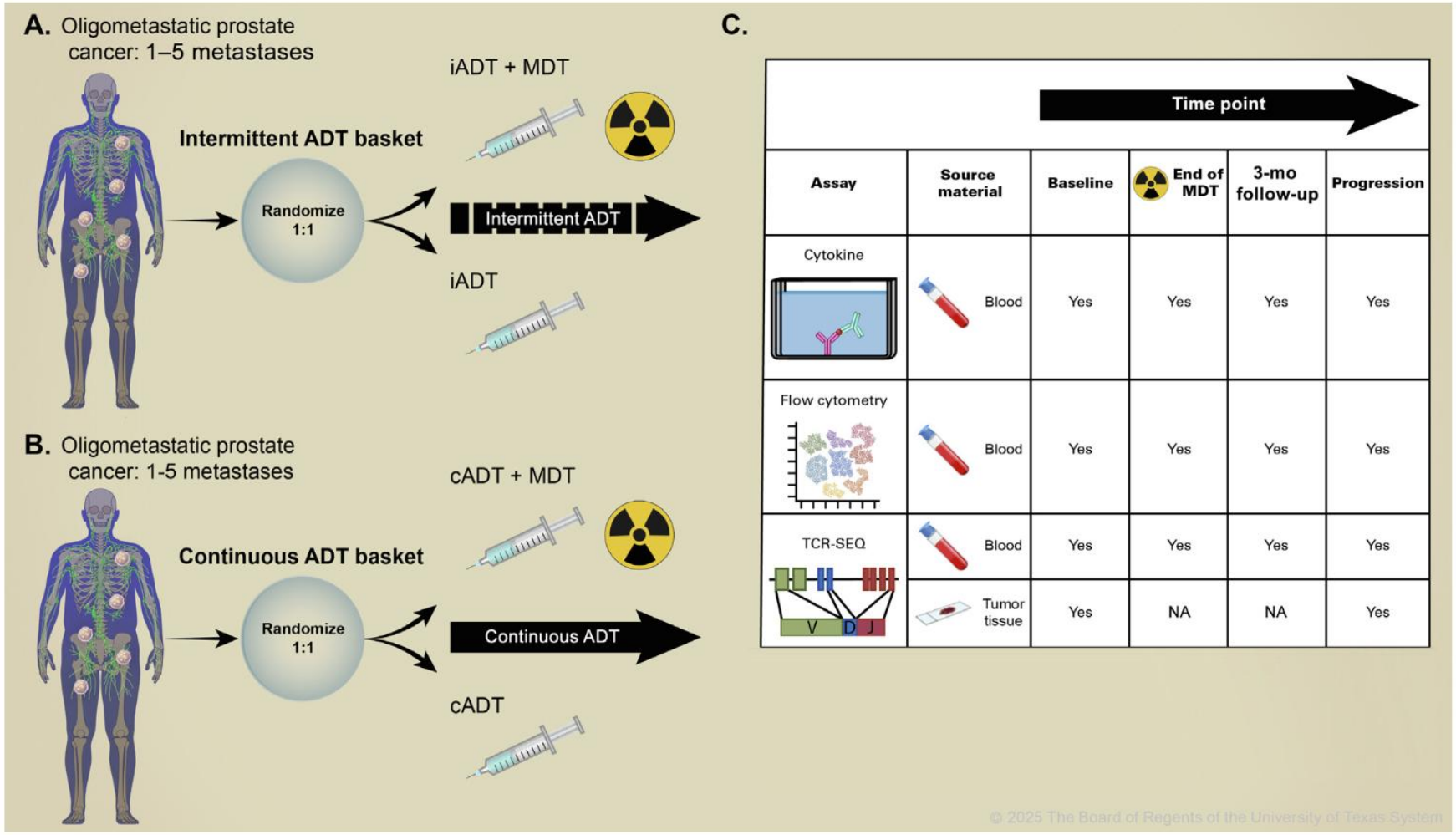


Fig. 1 – (A and B) Clinical and (C) translational study design of the phase 2 randomized EXTEND trial oligometastatic prostate cancer baskets. ADT = androgen deprivation therapy; cADT = continuous ADT; iADT = intermittent ADT; MDT = metastasis-directed therapy; NA = not applicable; TCR-SEQ = T-cell receptor sequencing.

https://doi.org/10.1016/j.eururo.2025.07.006

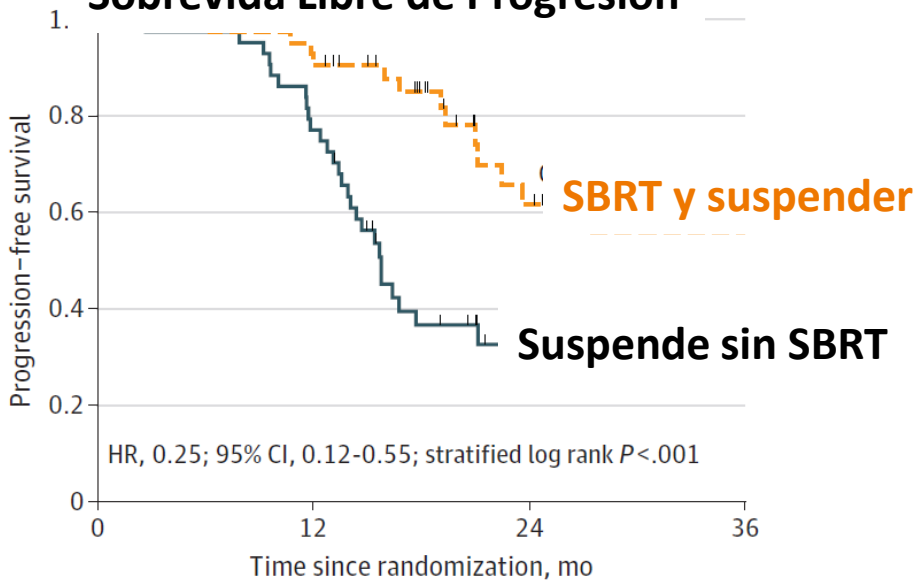
SBRT y suspender

JAMA Oncology | Original Investigation

Addition of Metastasis-Directed Therapy to Intermittent Hormone Therapy for Oligometastatic Prostate Cancer
The EXTEND Phase 2 Randomized Clinical Trial

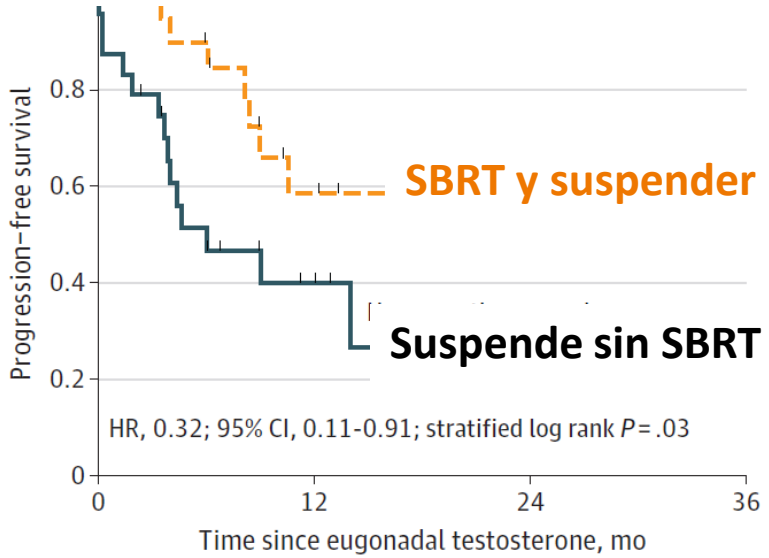
Chad Tang, MD; Alexander D. Sherry, MD; Cara Haymaker, PhD; Tharakeswara Bathala, MD; Suyu Liu, PhD; Bryan Fellman, MS; Lorenzo Cohen, PhD; Ana Aparicio, MD; Amado J. Zurita, MD; Alexandre Reuben, PhD; Enrica Marmonti, PhD; Stephen G. Chun, MD;

Sobrevida Libre de Progresión



No. at risk				
Hormone therapy only	44	34	5	1
Combined therapy	43	40	15	3

Sobrevida Libre de Progresión EUGONADAL



No. at risk				
Hormone therapy only	24	5	1	0
Combined therapy	24	8	1	0

Darolutamida + ADT en combinación sin Docetaxel no se encuentra aprobado por la agencia regulatoria INVIMA en Colombia para su uso en pacientes con cáncer de próstata sensible a la Castración (CPCSm). Bayer no promueve el uso de sus productos en indicaciones por fuera a las aprobadas por la agencia regulatoria.

ASCO Genitourinary Cancers Symposium

World-wide oligometastatic prostate cancer (omPC) meta-analysis leveraging individual patient data (IPD) from randomized trials (WOLVERINE): an analysis from the X-MET collaboration

Chad Tang, Alex Sherry, Hyunsoo Hwang, Giulio Francolini, Lorenzo Livi, Phuoc Tran, Paul Corn, Ana Aparicio, Gabriele Simontacchi, Ana Kiess, Jarey Wang, Valerie Fonteyne, Renee Bultijnck, Robert Olson, Stephen Harrow, Ethan Ludmir, Pierre Blanchard, Ryan Sun, David Palma, Piet Ost

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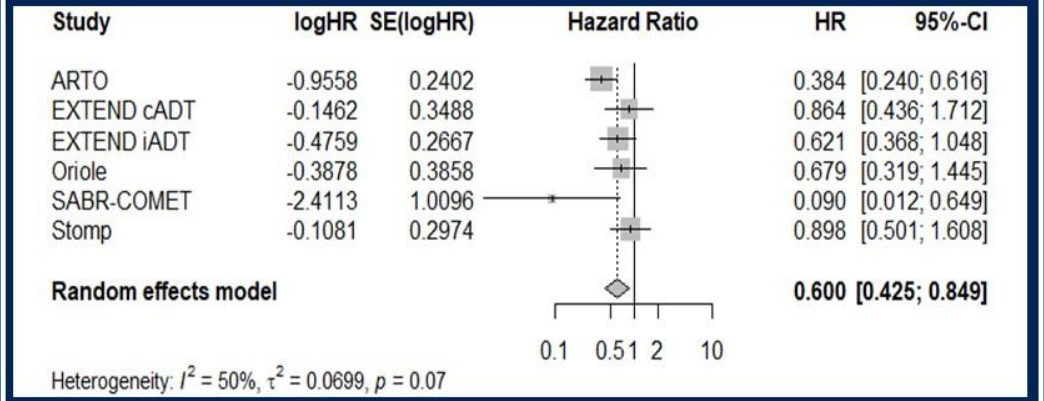
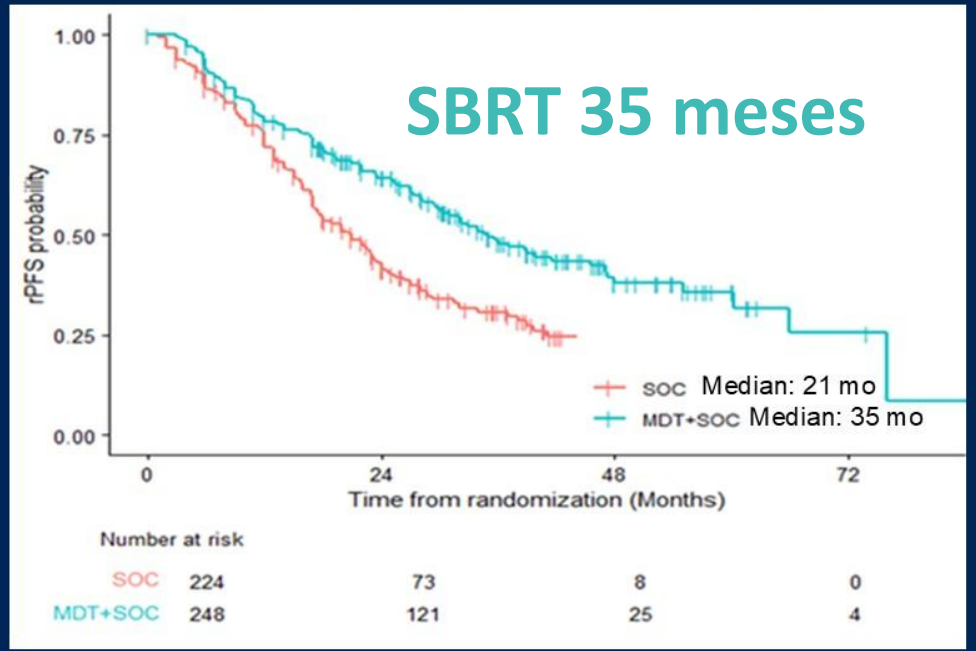
Results: Radiographic PFS

Trial Level Analysis:
Random effects model P=0.004



Cox Regression (Stratified by Trial):
MDT (vs SOC) HR: 0.59 (95% CI: 0.46-0.76), P <0.001



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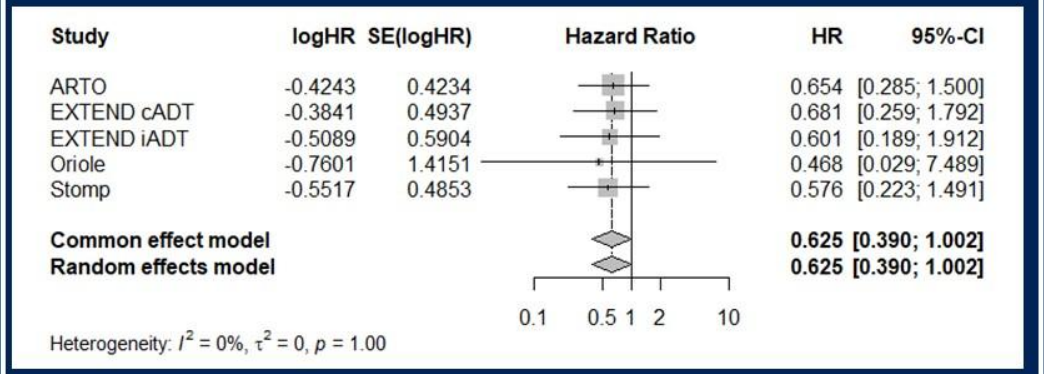
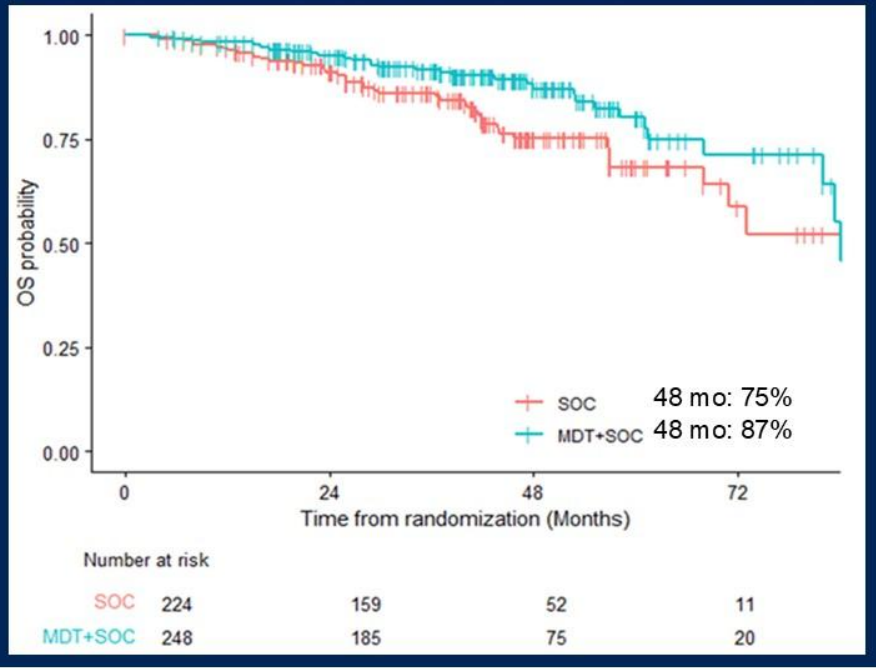
Results: Overall Survival

Trial Level Analysis:
Random effects model P=0.051



Cox Regression (Stratified by Trial):
MDT (vs SOC) HR: 0.64 (95% CI: 0.40-1.01), P =0.057



RADIOTERAPIA DIRIGIDA A LA METASTASIS (MDT)

OLIGOMETASTASICO DE NOVO

?

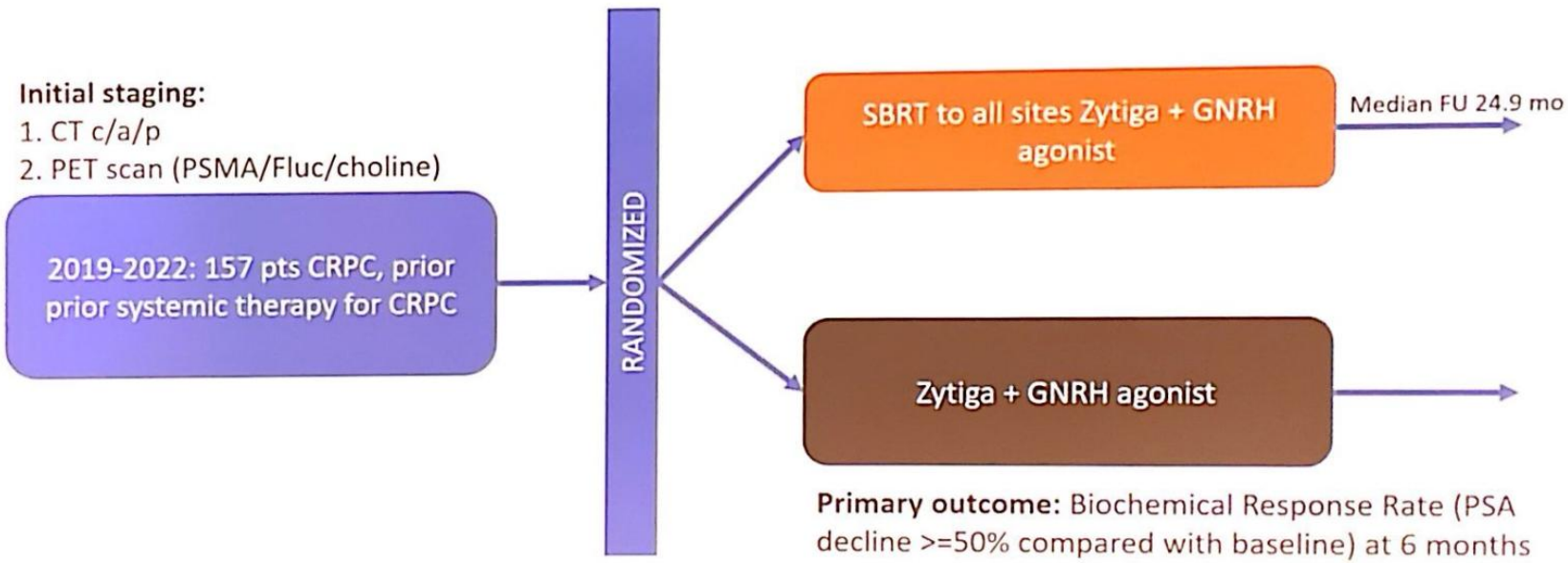
OLIGOMETASTASICO METACRONICO O RECURRENTE

OLIGOPROGRESION RESISTENTE A LA CASTRACION

?

EMUC25
13-16 November 2025
Prague, Czech Republic

ARTO

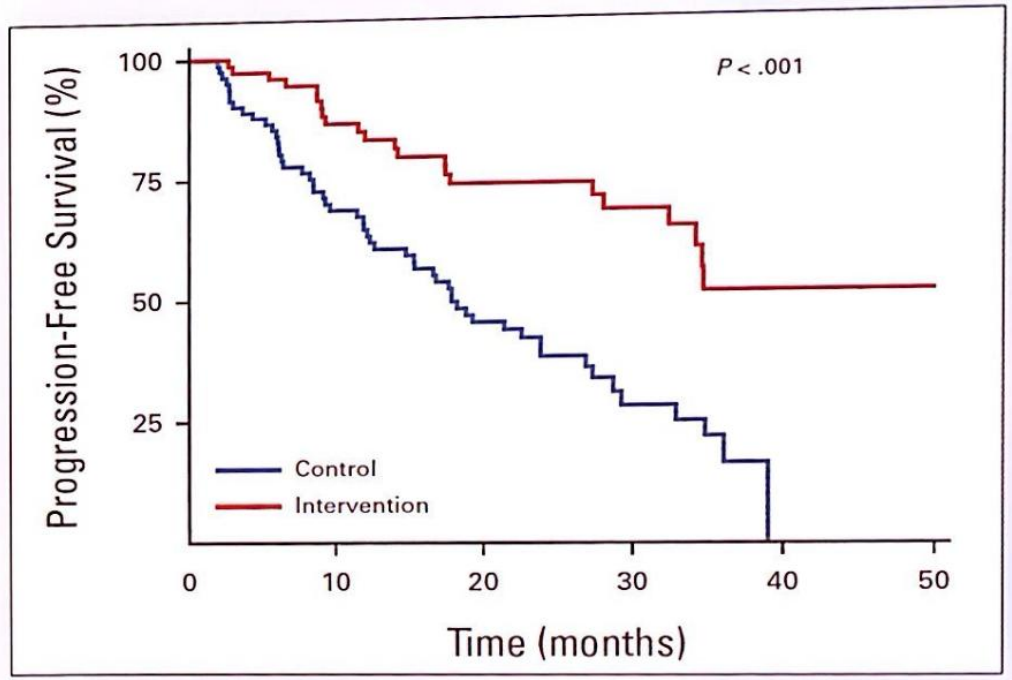


Francolini et al. JCO 2023

- **1º Endpoint: Biochemical Response**

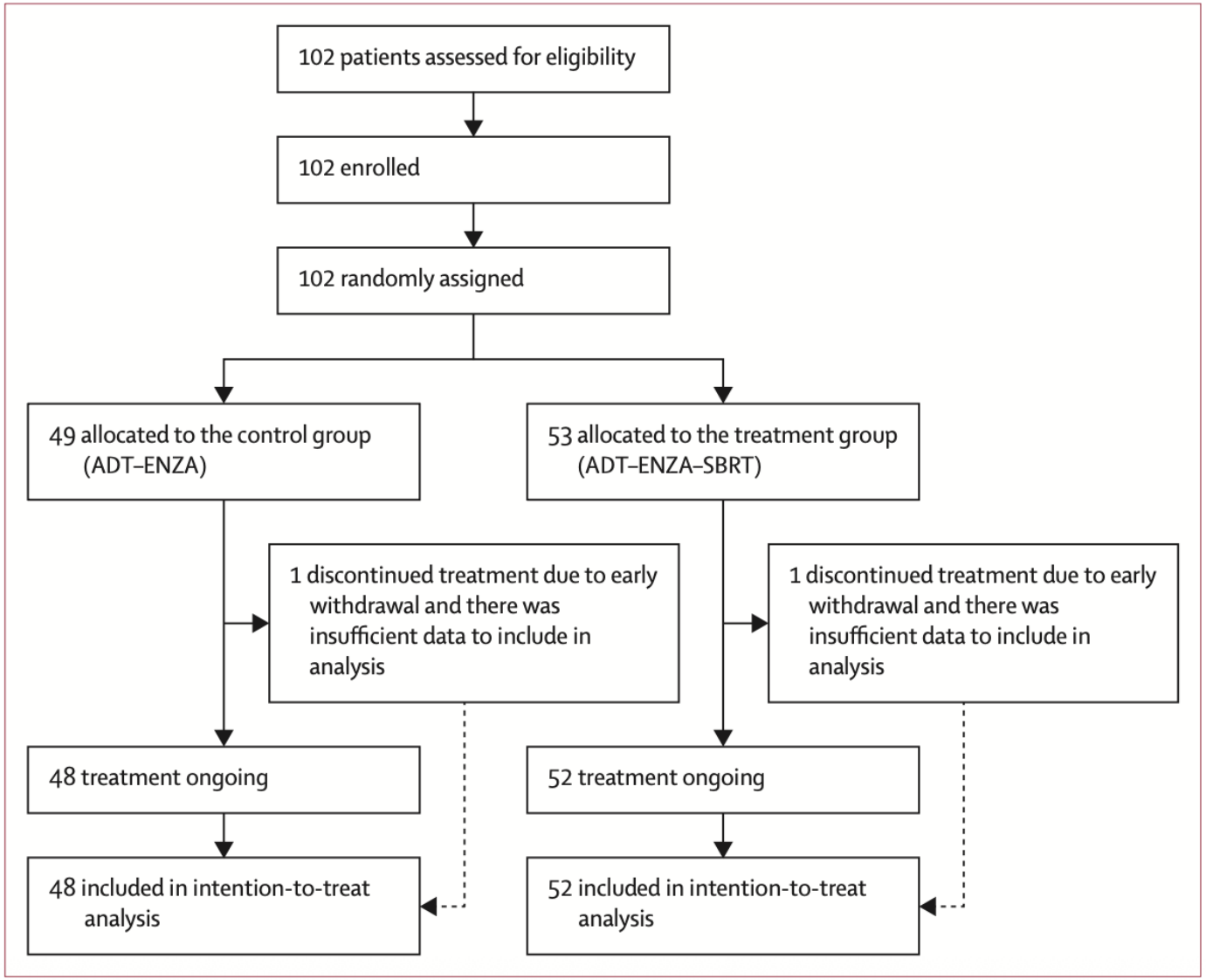
  92% vs 68.3% (*p=0.001*)

  CR: 56% vs 23.2% (*p<0.001*)
- Median time to next tx 36m vs 18m
- No differences in toxicity



Metastases-directed therapy in addition to standard systemic therapy in oligometastatic castration-resistant prostate cancer in Canada (GROUQ-PCS 9): a multicentre, open-label, randomised, phase 2 trial

Tamim Niazi, Fred Saad, Steven Tisseverasinghe, Rashmi Koul, Isabelle Thibault, Peter W M Chung, George Wakil, Michael Lock, Guila Delouya,



Lancet Oncol 2025; 26: 1158–67

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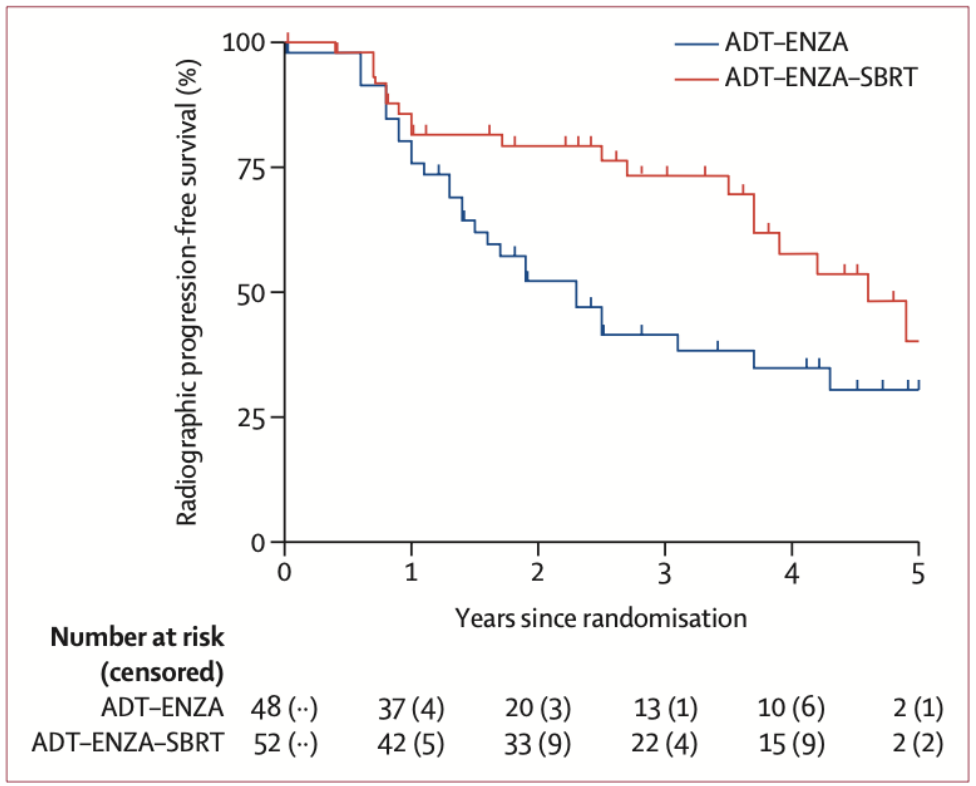


Figure 2: **Radiographic progression-free survival**

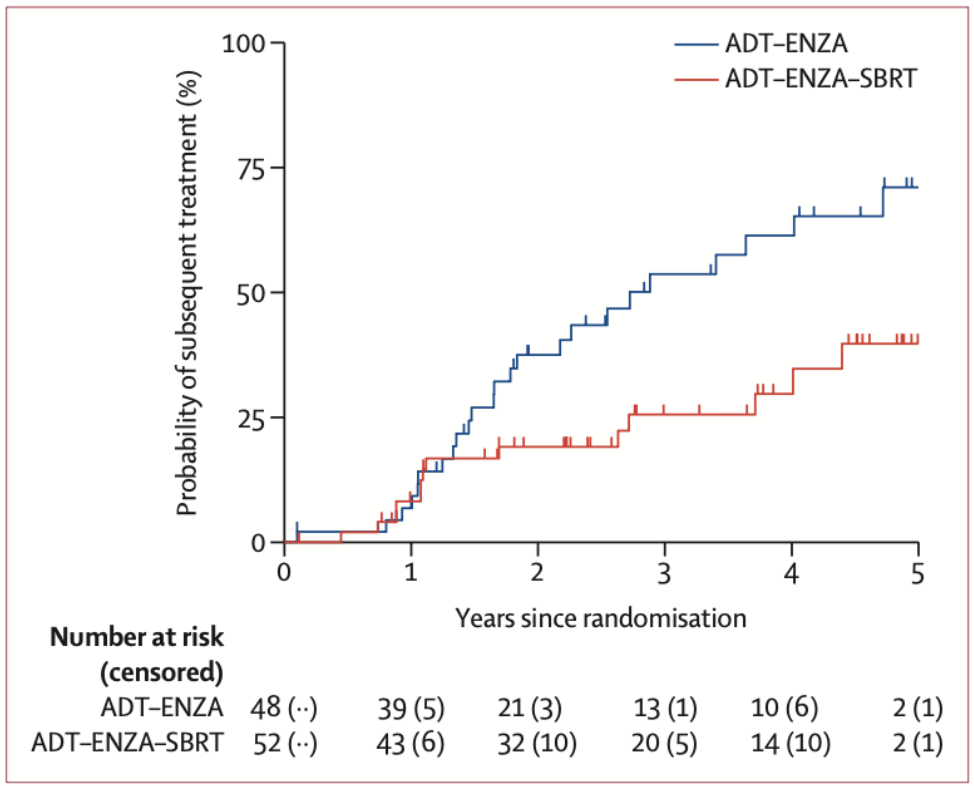


Figure 3: **Time to subsequent treatment from the date of randomisation**

Bajo volumen Recaído

APCCC ADVANCED PROSTATE CANCER CONSENSUS CONFERENCE

3. mHSPC

Consensus questions APCCC 2024

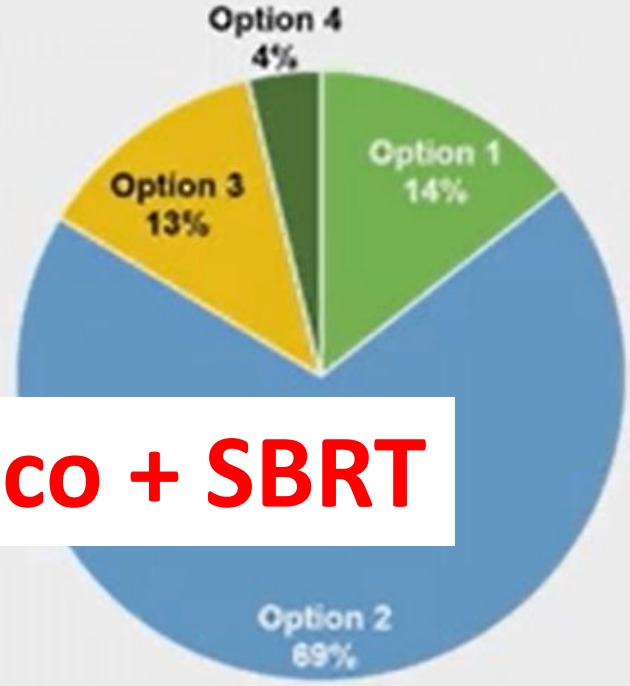
80.+ 83. In the majority of patients with metachronous low-burden mHSPC, what is your treatment recommendation?

Recaído Bajo Vol

1. Systemic therapy alone
2. Systemic therapy plus metastases directed therapy
3. Metastases directed therapy alone
4. Monitoring and no immediate treatment (**only for Q83**)
5. Abstain/unqualified to answer

Conventional imaging

Next-generation imaging and negative on conventional imaging



Trat sistémico + SBRT

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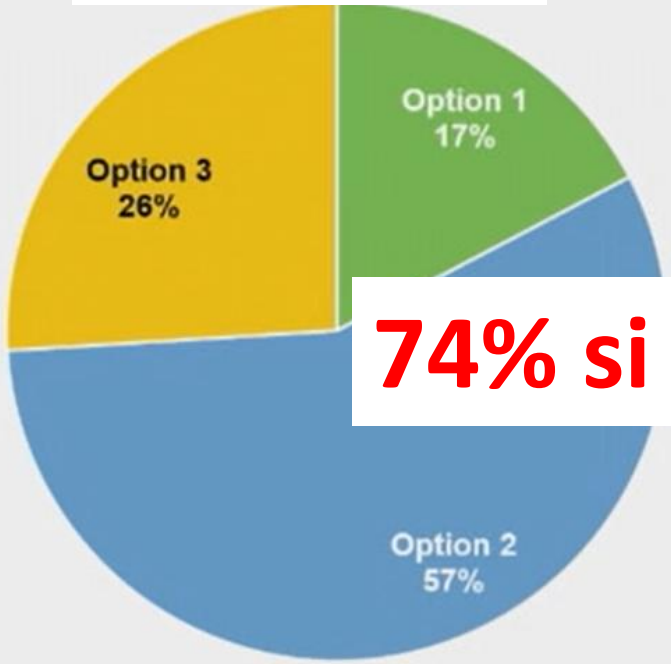
MDT en bajo volumen de novo

75. In the majority of patients with synchronous low-burden mHSPC on conventional imaging, do you recommend additional metastases directed therapy (if technically feasible) of all lesions?

1. Yes
2. Yes, but only if no relevant additional and/or untreatable lesions confirmed by next-generation imaging
3. No
4. Abstain/unqualified to answer

De Novo Bajo Vol



Option	Votes
Option 1	18
Option 2	59
Option 3	27
Abstain	2

Preliminary results. For interpretation of results please refer to publication, which will follow shortly after APCCC 2024 © APC Society (apccc.org)

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Mensajes para llevar a Casa

- Radioterapia al primario, estandar de manejo en bajo volumen y ¿algunos alto volumen?
- MDT en oligorecurrencia, especialmente con factores de alto riesgo
- ADT + Intensificacion sigue siendo el estandar de manejo en pte metastasico
- MDT en oligometastasico de novo, estudios fase 2 prometedores, ante falta de evidencia y baja toxicidad se esta utilizando frecuentemente
- MDT en resistencia a la castracion, aun menos evidencia, algunso estudios prometedores

GRACIAS.

XXII Congreso Colombiano de Cáncer